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Missouri Medicine

JOURNAL OF THE MISSOURI STATE MEDICAL ASSOCIATION

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JAN 27 1975

JANUARY, 1975
VOLUME 72, NUMBER 1

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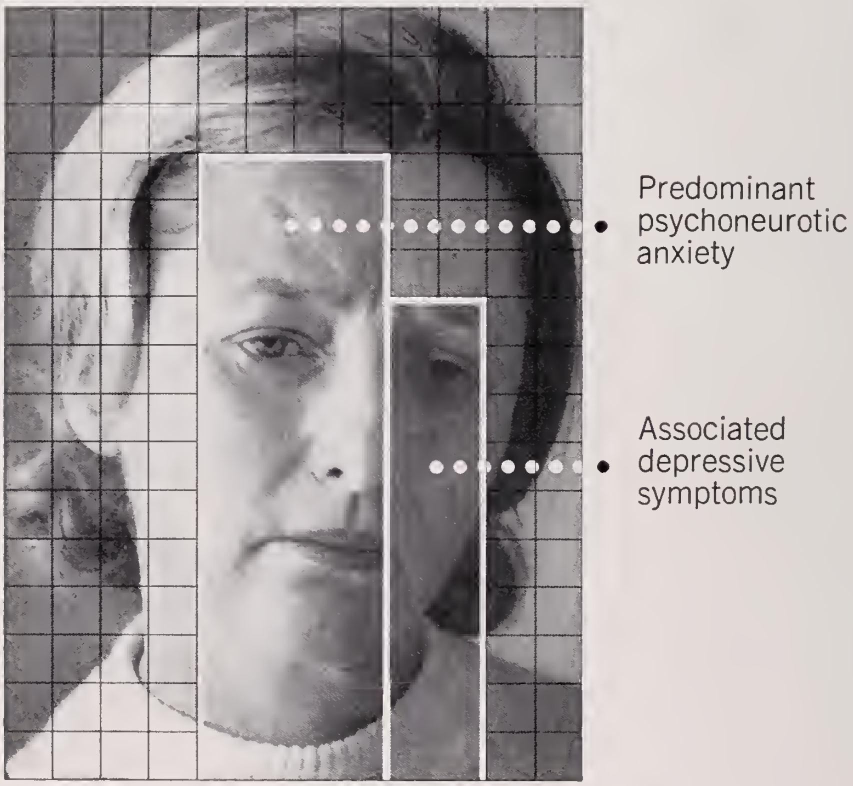
**117th MSMA Annual Session
April 17-20, 1975, St. Louis**

Both often


Predominant psychoneurotic anxiety
Associated depressive symptoms

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequ
and/or severity of grand mal seizures
require increased dosage of standard
convulsant medication; abrupt withdr
may be associated with temporary increase in frequency and/or severity o
seizures. Advise against simultaneous
gestion of alcohol and other CNS depr
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those with barbiturates and alcohol) h
occurred following abrupt discontinu
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associated with it are also
relieved.
There are other advan-
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in the patient within a few days rather than in a week or two, although it may take longer in some patients. In addition, Valium (diazepam) is generally well tolerated; as with most CNS-acting agents, caution patients against hazardous occupations requiring complete mental alertness.

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anxiety states
with associated
depressive symptoms

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habituation and dependence. In
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sion, or with suicidal tendencies.

Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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Missouri Medicine

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Illustrations should be glossy prints or drawings in India ink on white paper. They should not be mounted and name of author and figure number should be penciled lightly on the backs. Legends should appear on a separate sheet. Colored illustrations will be used when suitable if author assumes the actual cost.

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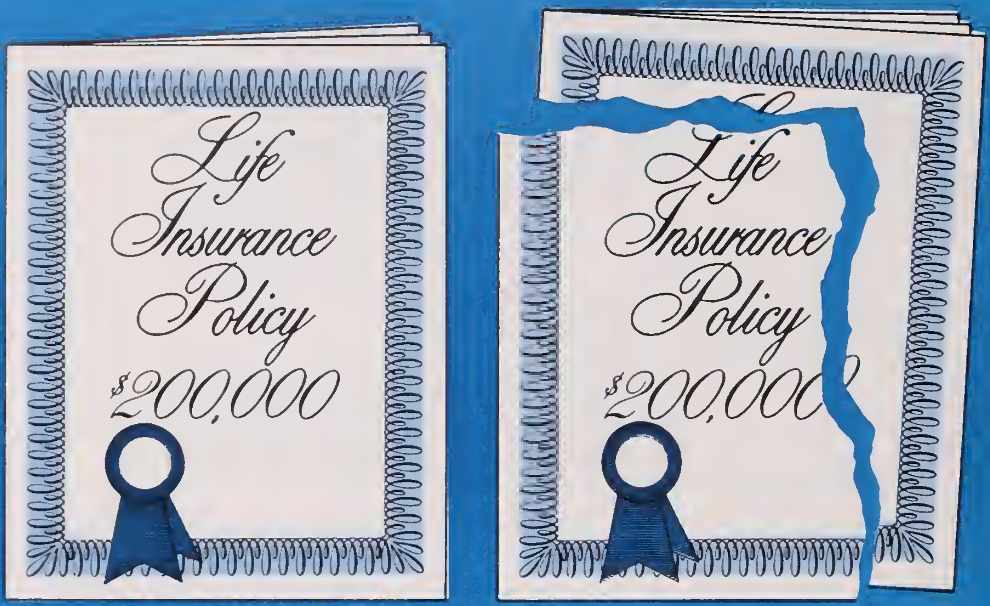
How much has inflation stolen from you, Doctor ...while you weren't looking?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MSMA

MISSOURI STATE MEDICAL ASSOCIATION

NEWS ROUND - UP

January, 1975

Council okays CME, malpractice projects

Implementation of a MSMA Continuing Medical Education program and approval of a new Associa-on-sponsored corporation to administer a pro-ssional liability insurance program were voted t the December meeting of the Council.

The Council approved for implementation a proposed **Accreditation Manual for Continuing Medical Education Activities** as drawn up by the Ad Hoc Committee on CME. The proposal will be ubmitted to the AMA for approval. The manual provides for accreditation for CME programs ponsored by county medical societies, hospitals, group practices and others.

The Council voted to charter the Mis-ouri State Medical Insurance, Inc., which would be the sponsor of a professional lia-ility insurance program for MSMA mem-ers. Also, the Council agreed to give Rol-ins Burdick Hunter 90 days to finalize ar-angements for the program.

MSMA members who cannot obtain malpractice overage during the interim period should contact MSMA Headquarters.

In other actions, the Council:

● Approved a proposed MSMA budget for 1975 f $447,803.

● Approved arrangements for a MSMA-ponsored travel plan to Hawaii in Novem-er, 1975. The trip would be in conjunction with the 1975 Clinical Session of the AMA. There will be separate departures from St. Louis and Kansas City.

● Dr. James C. Cope, MSMA President, an-ounced the appointment of Dr. Clement B. Gre-el, of St. Louis, as the Association's representa-ve on the Health Care Foundation/PSRO Support enter.

● Accepted the recommended wording for pro-osed changes in the MSMA Constitution and By-ws which, if approved by the 1975 House of Dele-ates, would provide for "Unified Membership ith the AMA." The House received the proposed mendment in 1974 with the final vote set for 1975. A copy of the wording has been sent to all county medical societies and will be published in MISSOURI MEDICINE.

● Voted to inform the Department of HEW of opposition to Utilization Review regulations scheduled to go into effect Feb. 1, 1975. Council also asked local societies, hospitals and PSRO's to express opposition to regulations (Article on regulations in this issue.)

● Was informed that Dr. Malcolm Todd, President of the AMA, will be in Kansas City, Jan. 28-29, to address the first graduating class of the Mid-Missouri Regional Council, Emergency Rescue Paramedics. Jackson County Medical Society will honor Dr. Todd on Jan. 28.

● Heard a report expressing the deleterious effects of H.B. 16204, as passed recently by the U.S. House of Representatives.

● Received the report of the Commission on Public Affairs.

● Agreed that the Committee on Voluntary Health Agencies could ask agencies in the state if they would be interested in sharing the cost of publishing an expanded directory of agencies to be presented in MISSOURI MEDICINE.

● Heard a report from Dr. Herbert R. Domke, Director of the Missouri Division of Health, which included information on the withdrawal of the mandatory requirements of the proposed Hospital Data Discharge Program and an epidemic of infectious syphilis in Missouri. (See article in this issue.)

● Received an update on the progress in planning for the 117th Annual Session of the MSMA, April 17-20, 1975, in St. Louis.

● Heard reports from the Medical School Deans, Woman's Auxiliary, MSMA Field Secretary, Missouri's Delegates to AMA and the Legislative Committee. (AMA Article in this issue. Legislative report will be published in February issue.)

New utilization review rules effective Feb. 1

HEW has published new regulations governing utilization review procedures, which will take effect Feb. 1, 1975, that call for the review of admissions of Medicare and Medicaid patients within 48 hours following admission.

HEW maintains that the regulations will assist the development of PSRO and "enable PSRO's to concentrate their efforts on relatively smaller areas of questionable professional activities."

The review committee will have to be supplied with the following: (1) identification of the eligible patient and physician; (2) date of admission; (3) the physician's plan of care which would be periodically reviewed and evaluated "by a physician and other personnel involved in the care of the eligible individual"; (4) the date of any operating room reservation; (5) the justification for emergency admission; (6) reasons for any continued stay and an "appropriate plan of care"; and (7) any other supporting material as the review committee may deem appropriate.

Infectious syphilis epidemic in Missouri

An epidemic of infectious syphilis in St. Louis and Kansas City "is the most difficult major infectious disease problem which the state and city and county health departments have faced in many years," said Dr. Herbert R. Domke, director of the Missouri Division of Health.

"It appears that changing sexual behavior with increased homosexuality and more middle-class sexual promiscuity are the reasons control measures which were effective 10 years ago have been unsuccessful in bringing the present epidemic under control," Dr. Domke said.

Reported cases in the last year have been four times as high as in the year before.

Raymond Bly, director of Venereal Disease Control for Missouri, said venereal disease control staff has been tripled in both metropolitan areas, but the teams effectiveness is troubled with poor reporting of cases, especially in the cases of homosexuals, and with doctors who simply fail to suspect syphilis in middle-class patients.

Of the 337 cases reported, 238 were males, with 50 per cent of those males naming contact of the same sex as compared with 20 per cent before the current epidemic.

Domke said the epidemic cannot be controlled until doctors not only consider syphilis transmitted by homosexual contact, but also report it to authorities. Health departments maintain absolute confidentiality, he said.

For assistance, doctors and patients can call the state health department, 751-3734.

News-in-Brief

PSRO information

Two area PSRO's in Missouri are making ava able to physicians a new pamphlet, "PSRO . . . What Now?"

Physicians in Area II may obtain a copy b writing, Mid-Missouri PSRO Foundation, P.O. Bc 253, Jefferson City, Mo. 65101. Physicians Area IV may write for a copy to Missouri Ar IV, Inc., 223A Professional Building, Springfiel Mo. 65806.

Director appointed

Charles Murfin has been appointed Amer ican Medical Association Regional Directc for the Midwest Region, which include Missouri.

Murfin was a field representative for th Republican National Committee and has bee with the AMA since September.

Medicare cost up

Medicare patients will be paying a Part A d ductible of $92 in 1975 for hospital care, mo than double the $40 deductible when the progra began in 1966.

Enrollment increases

A record total of 14,436 first-year med cal students were admitted last fall to th 114 medical schools in the U.S.

Total medical school enrollment is est mated at 53,735 by the AMA. The schoo will be graduating about 12,850 M.D.'s the spring of 1975.

'Tumors and Rumors'

What's in first place these days on the Mec cal Hit Parade? It's a topical ballad, compose and performed for a stereo record album b Springfield's Singing Doctors, called "Tumo and Rumors."

The six physicians' newest effort — and it is supreme effort for this off-beat group to sing c key — is The Singing Doctors "Keep You i Stitches." Their leader, surgeon James T. Brow calls it "cutting humor." Baritone Hal Lurie, a internist, says it's strictly for "insiders," mea ing the entertainment is most enjoyed by tho understanding terminology of the medical world.

All proceeds from sales of the album go to th group's own medical-education foundation. To dat over 170 scholarship awards have been made deserving young doctors-to-be.

Other songs, recorded live at one of the Sin ing Doctors' many personal appearances at mec cal meetings in some 15 states, include "Tl Best Thing in Life Are Fees" and "Doctorsh Harmony." Then there are melodies dealing wi vasectomy, psoriasis, transplantation, the men pause, and a special "doctors' tribute" to t IRS, "The Yellow Rose of Taxes."

The album may be obtained by sending $5. for one copy, or $10.95 for two, to the Gree County Medical Society, Professional Buildin Springfield, Mo. 65806. (Tapes are unavailable.)

QUALITY CONTROL MARK

Summary of House actions

AMA approves special $60 assessment

A mandatory, special assessment of $60 for AMA members was approved by the House of Delegates at the 28th Clinical Convention in Portland. The assessment, effective Jan. 1, 1975, for AMA members excluding students, interns and residents, is expected to improve immediate cash-flow problems and help build up depleted financial reserves.

Rejecting a $90 dues increase proposed by the Board of Trustees, Delegates instead called for a Special Committee of the House to study the dues issue and report back at the 1975 Annual Meeting.

The House was reminded that the Association has operated at a deficit for four of the last five years, and that cash reserves have been seriously depleted during that time. In addition, AMA finances in 1974 were adversely affected by inflationary pressures.

After almost six hours of comment and deliberation on Tuesday afternoon and Wednesday morning, the Delegates adopted the $60 special assessment as a stop-gap measure.

In related actions, the House strongly urged the Board of Trustees to restore in a "holding pattern" the structure of several councils and committees which were to have been eliminated, and to maintain present publication schedules for JAMA, all specialty journals, and Prism.

The House also approved advertising as a legitimate function in AMA publications, and urged that the present full and unrestricted advertising program continue pending further study and a report at the June meeting.

Housestaff: The Delegates adopted several recommendations designed to strengthen housestaff participation in the AMA.

They include: that the elected Executive Committee of the Intern and Resident Business Session assume advisory responsibilities of the Committee on Housestaff Affairs, which will be dissolved; that programs and priorities of the Department of Housestaff Affairs be developed annually by the department director and the chairman of the I & R Business Session, subject to review and approval of the Board of Trustees; and that responsibility for the editorial content of the Housestaff Newsletter and for the distribution of I & R Business Session reports be exercised by the Session's Executive Committee subject to AMA approval and review.

Professional Liability: During a discussion of malpractice problems, the House adopted a recommendation calling for the Board to give "priority attention" to providing legal counsel and advice to AMA members and state societies in the event their professional liability insurance is not renewed.

Clinical/Scientific Format: A separation of the fall business meetings of the House and the scientific meetings will be permitted beginning in 1977.

The new format was devised to allow regional scientific programming. The scientific assemblies will continue to be held in conjunction with Annual Meetings, however.

In other actions on internal matters, the House:

— Called for a definitive report at the 1975 annual meeting of AMA activities and programs related to PSRO.

— Rejected a Board proposal to replace the Council on Legislation and many functions of the AMPAC Board of Directors with a new Council on Public Affairs.

— Referred a report on direct representation in the House of medical specialty societies back for further consideration.

PHYSICIANS — HOSPITALS — MEDICAL SCHOOLS:

Due Process: The House adopted several recommendations which reaffirm the rights of all physicians, including housestaff and medical students, to due process. The House adopted as AMA policy the proposition that a student's academic records should be open to inspection so that he/she may profit educationally.

Housestaff Contracts: The House adopted a set of revised guidelines for housestaff contracts which had been approved by the Council on Medical Education, the Board of Trustees and the Council on Medical Service.

Biomedical Research: The House adopted a 10-point statement on biomedical research urging more federal funding with fewer restrictions. The report sharply criticizes federal cuts in independent research grants and in the budgets of the National Institutes of Health.

Physician Competence: Delegates adopted a Board report calling for strong programs of continuing medical education and peer review as alternatives to relicensure since "the difficulties inherent in relicensure clearly outweigh any potential benefits."

Specific recommendations include encouragement and support for the AMA, constituent societies, JCAH and other bodies in expanding CME programs; that the AMA give high priority to enhancing and reviewing effective methods of continuing competence; that patient satisfaction should be included in performance evaluation; and that well-designed peer review programs be endorsed as an important component of performance evaluation. The House also stressed that evaluation of performance, rather than knowledge per se, is the best method of appraising competence in patient care.

In other actions related to physicians, hospitals and medical schools, the House:

— Adopted an amended resolution which urges that duplication of local peer review procedures be avoided; that medical audit or utilization protocols used in screening be limited to those which are demonstrated to be valid, reliable and which do not add needlessly to cost; and that when local peer review groups recognize that a hospital medical staff has adequate medical audit and utilization procedures, that fact should be recognized by governmental agencies and JCAH.

— And requested a "comprehensive report" be presented at the 1975 Annual Meeting on questions and issues related to foreign medical graduates.

PHYSICIANS AND THE GOVERNMENT:

National Health Insurance: Delegates gave the Board a vote of confidence for its efforts to develop new approaches to NHI which maintain traditional AMA goals. The House adopted a report containing basic guidelines for NHI deliberations.

The guidelines include minimum federal involvement in the administration of any NHI program; state jurisdiction for licensure of physicians and regulation of insurance; no Social Security tax financing and administration of any program; funding through federal revenues, state revenues and private funds including employer-employee contributions for private health insurance; comprehensive coverage for basic and catastrophic needs; and the maintenance of pluralism in health delivery.

(See next page)

Manpower and Planning Bills: The House adopted an emergency resolution expressing unanimous opposition to U.S. House of Representatives bills which would divide the nation into health service planning areas and treat health care as a public utility, and which would require medical students to reimburse the government for capitation.

Prepaid Plans: Delegates adopted a Judicial Council report which cautions that the payment of bonuses to physicians in prepaid health care plans such as HMO's for minimizing the utilization of services may interfere with the physician's obligations to his patients.

In other actions related to physicians and the government, the House:

— Urged that Medicare intermediaries adhere strictly to regulations for reimbursement of chiropractors to those procedures defined in the regulations.

— Encouraged the acceptance and use by physicians of the AMA's Uniform Health Insurance Claim Form, and urged insurors to study the possible use of plastic "charge card" type identification cards for imprinting basic data on insurance forms.

— And urged the government to continue its present 55 m.p.h. speed limit for at least a one-year period, noting that traffic fatalities have declined 14.8% since the speed limit was imposed last year.

PHYSICIANS AND THE PUBLIC:

Weight Reducation Clinics: The House took a strong policy position against the use of human chorionic gonadotropin for use in weight reduction. The House further resolved "that the AMA warn our citizens about the potential danger of such a weight control program."

Care for Disadvantaged: "Vigorous, high-priority" efforts to foster health care programs for disadvantaged segments of the population were recommended.

Maternity and Newborn Care: The House adopted two reports which reaffirm AMA policy to encourage insurance coverage of the newborn from the moment of birth, urge the health insurance industry to offer coverage for obstetrical care and any complications, and recommend that the insurance industry — as well as government — offer such coverage on the broadest possible basis.

In other actions relative to physicians and the public, the House:

— Supported state legislation to regulate the practice of acupuncture. The new policy says acupuncture should only be performed in research settings by a physician or under the direct supervision of a physician.

— Reaffirmed AMA endorsement of the fluoridation of water supplies.

— Adopted a report which holds that, "It is not unethical for a physician to authorize the listing of his name and practice in a (community) directory for professional or lay use which is intended to list all physicians in the community on a uniform and nondiscriminatory basis. The listing shall not include any self-aggrandizing statement or qualitative judgment regarding the physician's skills or competence."

— Endorsed the right of a physician to dispense ampicillin-probenecid for gonorrhea patients, reflecting an opinion that physicians have a duty to protect the confidentiality of patients who contract gonorrhea.

— And adopted a substitute resolution calling for the government to develop adequate safeguards for the transportation and storage of hazardous materials such as radioactive materials.

Dr. John Henry McCurry (center) is presented a cake from the MSMA by Dr. Carol F. Williams (left) in observance of Dr. McCurry's 100th birthday recently. Dr. William H. Olmsted, 87, looks on. Drs. McCurry and Olmsted were organizers of the MSMA Fifty Year Club. All are from St. Louis.

Telephone 'consultations' will soon be available

A new telephone directory, listing nearly 800 access numbers for "Brief Medical Consultations," soon will be distributed to the medical practitioners of Missouri.

The directory was produced by the Information Science Group of the University of Missouri School of Medicine in cooperation with the Missouri Regional Medical Program.

These medical consultations consist of taped messages contained in the Audio Message Center operated by the Information Science Group, and provide up-to-date, automatic access to information useful in the diagnosis, treatment and management of a broad variety of ailments. The system can be accessed at any time of day or night by telephone.

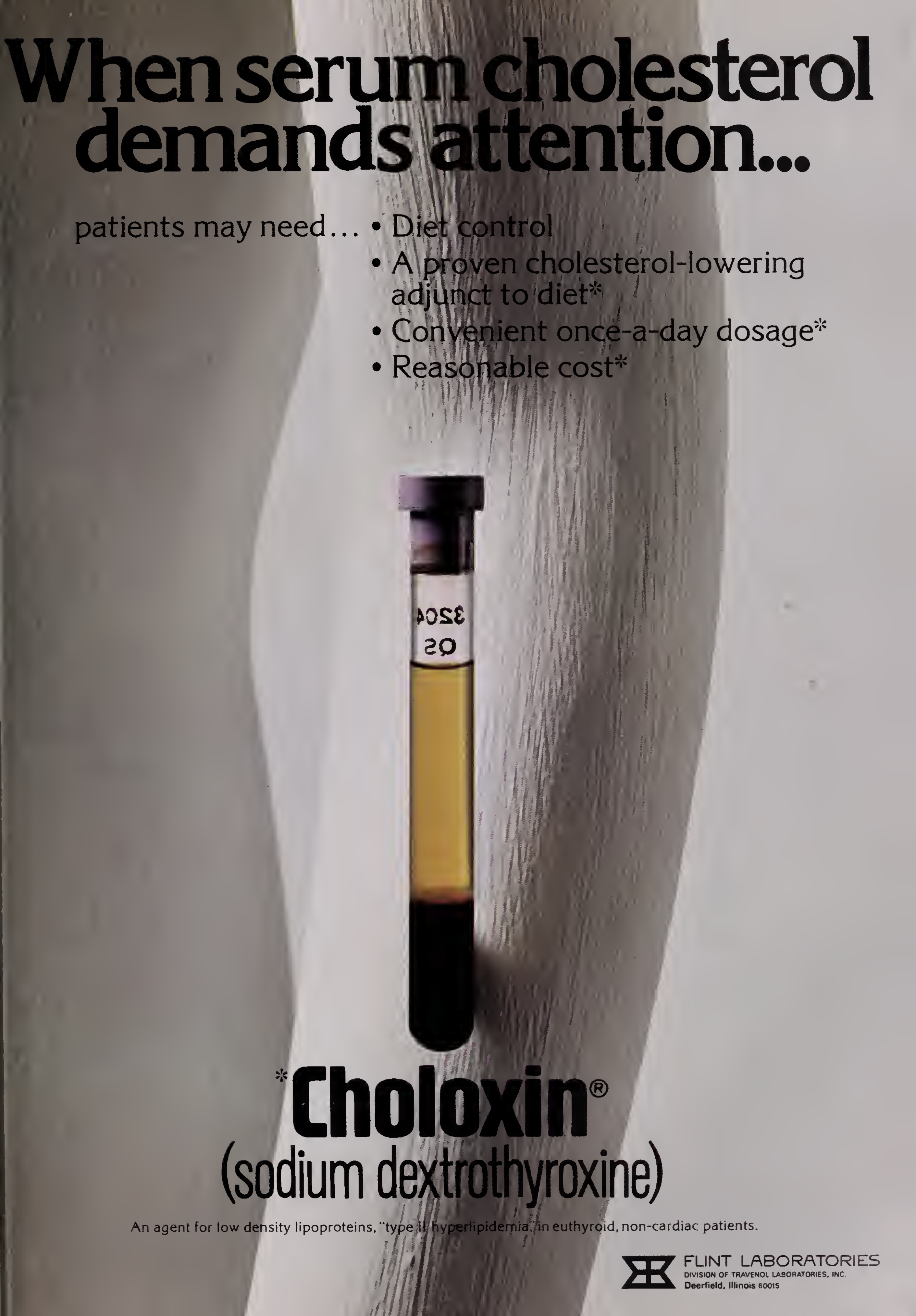
The messages were taped by professionals and are intended solely for professionals. Distribution of the new directory will be only to professionals.

All messages are grouped under 27 major categories. Practitioners readily will be able to select the category appropriate to the information desired. Where the subject matter title might logically be listed under more than one category, it is so listed. Cancer messages are further separated under 19 subcategories.

Each message is described by title, author, time length and the last four digits of its telephone number. The first three numbers for all messages are "881."

In the Columbia toll-free area, one simply dials the number and the message is automatically reached. From outside the Columbia area, precede the directory number by "1-314" as for any long distance call to Columbia.

The American Cancer Society has provided a special state-wide toll-free service for some 200 listings of cancer related "consultations." The directory explains how these can be reached at no charge to the caller.



When serum cholesterol demands attention...

patients may need...
- Diet control
- A proven cholesterol-lowering adjunct to diet*
- Convenient once-a-day dosage*
- Reasonable cost*

***Choloxin®**

(sodium dextrothyroxine)

An agent for low density lipoproteins, "type II" hyperlipidemia," in euthyroid, non-cardiac patients.

FLINT LABORATORIES
DIVISION OF TRAVENOL LABORATORIES, INC.
Deerfield, Illinois 60015

Choloxin® (sodium dextrothyroxine)

The Lipid-Lowering Agent with Once-A-Day Dosage

Four strengths . . . 1, 2, 4, and 6 mg. . . . are available making the scored tablet regimen a flexible dosage system. And, for most patients, CHOLOXIN tablets offer once-a-day dosage.

AN IMPORTANT NOTE:
It has not been established whether the drug-induced lowering of serum cholesterol or lipid levels has a detrimental, beneficial, or no effect on the morbidity or mortality due to atherosclerosis or coronary heart disease. Several years will be required before current investigations will yield an answer to this question.

CHOLOXIN® (sodium dextrothyroxine) Single-Tablet-A-Day Dosage Schedules

See prescribing information in package insert reproduced below.

	Starting Dosage	Increased Monthly by	Usual Maintenance	Maximal Recommended
Adult Hypercholesterolemic	1.0-2.0 mg.	1.0-2.0 mg.	4.0-8.0 mg.	4.0-8.0 mg.
Pediatric Hypercholesterolemic	0.05 mg./kg. body weight	0.05 mg./kg.	0.1 mg./kg. body weight	4.0 mg.
Hypothyroid Cardiac	0.5-1.0 mg.	1.0 mg.	4.0 mg.	4.0 mg.

Choloxin®
(sodium dextrothyroxine)

Description
CHOLOXIN (sodium dextrothyroxine) is the sodium salt of the dextrorotatory isomer of thyroxine. It is chemically described as D-3,5,3′,5′-tetraiodothyronine sodium salt.

Actions
The predominant effect of CHOLOXIN (sodium dextrothyroxine) is the reduction of serum cholesterol levels in hyperlipidemic patients. Beta lipoprotein and triglyceride fractions may also be reduced from previously elevated levels.

Most of the available evidence indicates that CHOLOXIN stimulates the liver to increase catabolism and excretion of cholesterol and its degradation products via the biliary route into the feces. Cholesterol synthesis is not inhibited and abnormal metabolic end-products do not accumulate in the blood.

Indications
This is not an innocuous drug. Strict attention should be paid to the indications and contraindications.

CHOLOXIN (sodium dextrothyroxine) is an antilipidemic agent used as an adjunct to diet and other measures for the reduction of elevated serum cholesterol (low density lipoproteins) in euthyroid patients with no known evidence of organic heart disease.

The drug is also indicated in the treatment of hypothyroidism in patients with cardiac disease who cannot tolerate other types of thyroid medication.

Before prescribing, note the following: Results from a randomized clinical study have indicated a possible adverse effect when CHOLOXIN is administered to a patient receiving a digitalis preparation. There may be an additive effect. This additive effect may possibly stimulate the myocardium excessively in patients with significant myocardial impairment. CHOLOXIN dosage should not exceed 4 mg per day when the patient is receiving a digitalis preparation concomitantly. Careful monitoring of the total effect of both drugs is important.

It has not been established whether the drug-induced lowering of serum cholesterol or lipid levels has a detrimental, beneficial, or no effect on the morbidity or mortality due to atherosclerosis or coronary heart disease. Several years will be required before current investigations will yield an answer to this question.

Contraindications
The administration of CHOLOXIN (sodium dextrothyroxine) to euthyroid patients with one or more of the following conditions is contraindicated:

1. Known organic heart disease, including angina pectoris; history of myocardial infarction; cardiac arrhythmia or tachycardia, either active or in patients with demonstrated propensity for arrhythmias; rheumatic heart disease; history of congestive heart failure; and decompensated or borderline compensated cardiac status.
2. Hypertensive states (other than mild, labile systolic hypertension).
3. Advanced liver or kidney disease.
4. Pregnancy.
5. Nursing mothers.
6. History of iodism.

Warnings
CHOLOXIN (sodium dextrothyroxine) may potentiate the effects of anticoagulants on prothrombin time. Reductions of anticoagulant dosage by as much as 30% have been required in some patients. Consequently, the dosage of anticoagulants should be reduced by one-third upon initiation of CHOLOXIN therapy and the dosage subsequently readjusted on the basis of prothrombin time. The prothrombin time of patients receiving anticoagulant therapy concomitantly with CHOLOXIN therapy should be observed as frequently as necessary, but at least weekly, during the first few weeks of treatment.

In the surgical patient, it is wise to consider withdrawal of the drug two weeks prior to surgery if the use of anticoagulants during surgery is contemplated.

When CHOLOXIN is used as thyroid replacement therapy in hypothyroid patients with concomitant coronary artery disease (especially those with a history of angina pectoris or myocardial infarction) or other cardiac disease, treatment should be initiated with care. Special consideration of the dosage schedule of CHOLOXIN is required. This drug may increase the oxygen requirements of the myocardium, especially at high dosage levels. Treated subjects with coronary artery disease must be seen at frequent intervals. If aggravation of angina or increased myocardial ischemia, cardiac failure, or clinically significant arrhythmia develops during the treatment of hypothyroid patients, the dosage should be reduced or the drug discontinued.

Special consideration must be given to the dosage of other thyroid medications used concomitantly with CHOLOXIN. As with all thyroactive drugs, hypothyroid patients are more sensitive to a given dose of CHOLOXIN than euthyroid patients.

Epinephrine injection in patients with coronary artery disease may precipitate an episode of coronary insufficiency. This condition may be enhanced in patients receiving thyroid analogues. These phenomena should be kept in mind when catecholamine injections are required in sodium dextrothyroxine-treated patients with coronary artery disease.

Since the possibility of precipitating cardiac arrhythmias during surgery may be greater in patients treated with thyroid hormones, it may be wise to discontinue CHOLOXIN in euthyroid patients at least two weeks prior to an elective operation. During emergency surgery in euthyroid patients, and in surgery in hypothyroid patients in whom it may be advisable to withdraw therapy, the patients should be carefully observed.

There are reports that sodium dextrothyroxine in diabetic patients is capable of increasing blood sugar levels with a resultant increase in requirements of insulin or oral hypoglycemic agents. Special attention should be paid to parameters necessary for good control of the diabetic state in dextrothyroxine-treated subjects and to dosage requirements of insulin or other antidiabetic drugs. If sodium dextrothyroxine is later withdrawn from patients who had required an increase of insulin (or oral hypoglycemic agents) dosage during its administration, the dosage of antidiabetic drugs should be reduced and adjusted to maintain good control of the diabetic state.

When either or both impaired liver or kidney function are present, the advantages of CHOLOXIN therapy must be weighed against the possibility of deleterious results.

Usage in Women of Childbearing Age
Women of childbearing age with familial hypercholesterolemia or hyperlipemia should not be deprived of the use of this drug; it can be given to those patients exercising strict birth control procedures. Since pregnancy may occur despite the use of birth control procedures, administration of CHOLOXIN (sodium dextrothyroxine) to women of this age group should be undertaken only after weighing the possible risk to the fetus against the possible benefits to the mother. Teratogenic studies in two animal species have resulted in no abnormalities in the offspring.

Precautions
It is expected that patients on dextrothyroxine therapy will show greatly increased serum protein-bound-iodine levels. These increased serum PBI values are evidence of absorption and transport of the drug, and should NOT be interpreted as evidence of hypermetabolism; similarly, they may not be used for titrating the effective dose of CHOLOXIN (sodium dextrothyroxine). PBI values in the range of 10 to 25 mcg% in treated patients are common.

If signs or symptoms of iodism develop during CHOLOXIN therapy, the drug should be discontinued.

A few children with familial hypercholesterolemia have been treated with CHOLOXIN for periods of one year or longer with no adverse effects on growth. However, it is recommended that the drug be continued in patients in this age group only if a significant serum cholesterol-lowering effect is observed.

Adverse Reactions
The side effects attributed to dextrothyroxine therapy are, for the most part, due to increased metabolism, and may be minimized by following the recommended dosage schedule. Adverse effects are least commonly seen in euthyroid patients with no signs or symptoms of organic heart disease; the incidence of adverse effects is increased in hypothyroid patients, and is highest in those patients with organic heart disease superimposed on the hypothyroid state.

In the absence of known organic heart disease, some cardiac changes may be precipitated during sodium dextrothyroxine therapy. In addition to angina pectoris, arrhythmia consisting of extrasystoles, ectopic beats, or supraventricular tachycardia, ECG evidence of ischemic myocardial changes and increase in heart size have been observed. Myocardial infarctions, both fatal and non-fatal, have occurred, but these are not unexpected in untreated patients in the age groups studied. It is not known whether any of these infarcts were drug related.

Changes in clinical status that may be related to the metabolic action of the drug include the development of insomnia, nervousness, palpitations, tremors, loss of weight, lid lag, sweating, flushing, hyperthermia, hair loss, diuresis, and menstrual irregularities. Gastrointestinal complaints during therapy have included dyspepsia, nausea and vomiting, constipation, diarrhea, and decrease in appetite.

Other side effects reported to be associated with CHOLOXIN (sodium dextrothyroxine) therapy include the development of headache, changes in libido (increase or decrease), hoarseness, tinnitus, dizziness, peripheral edema, malaise, tiredness, visual disturbances, psychic changes, paresthesia, muscle pain, and various bizarre subjective complaints. Skin rashes, including a few which appeared to be due to iodism, and itching have been attributed to dextrothyroxine by some investigators. Gallstones have been discovered in occasional dextrothyroxine-treated patients and cholestatic jaundice has occurred in one patient, although its relationship to CHOLOXIN therapy was not established.

In several instances, the previously existing conditions of the patient appeared to continue or progress during the administration of CHOLOXIN; a worsening of peripheral vascular disease, sensorium, exophthalmos, and retinopathy have been reported.

CHOLOXIN potentiates the effects of anticoagulants, such as warfarin or Dicumarol, on prothrombin time, thus indicating a decrease in the dosage requirements of the anticoagulants. On the other hand, dosage requirements of antidiabetic drugs have been reported to be increased during dextrothyroxine therapy (see WARNINGS section).

Dosage and Administration
For **adult** euthyroid hypercholesterolemic patients, the recommended maintenance dose of CHOLOXIN (sodium dextrothyroxine) is 4 to 8 mg per day. The initial daily dose should be 1 to 2 mg to be increased in 1 to 2 mg increments at intervals of not less than one month to a maximum level of 4 to 8 mg daily, if that dosage level is indicated to effect the desired lowering of serum cholesterol.

When used as partial or complete substitution therapy for levothyroxine in hypothyroid patients with cardiac disease who cannot tolerate other types of thyroid medication, the initial daily dose should be 1 mg to be increased in 1 mg increments at intervals of not less than one month to a maximum level of 4 to 8 mg daily, preferably the lower dosage. The maximum in patients receiving digitalis therapy is 4 mg.

For **pediatric** hypercholesterolemic patients, the recommended maintenance dose of CHOLOXIN is approximately 0.1 mg per kilogram. The initial daily dosage should be approximately 0.05 mg per kilogram to be increased in up to 0.05 mg per kilogram increments at monthly intervals. The recommended maximal dose is 4 mg daily, if that dosage is indicated to effect the desired lowering of serum cholesterol.

If new signs or symptoms of cardiac disease develop during the treatment period, the drug should be withdrawn.

How Supplied
CHOLOXIN (sodium dextrothyroxine) is supplied in prescription packages of scored 1, 2, 4, and 6 mg tablets.

FLINT LABORATORIES
DIVISION OF TRAVENOL LABORATORIES INC
Deerfield, Illinois 60015

The patient on uricosurics:
another type for Tylenol®
(acetaminophen)

When the patient on uricosuric herapy requires an analgesic, a new roblem arises. Aspirin in the usual nalgesic doses inhibits the action of ricosurics.[1,2]

TYLENOL (acetaminophen), on he other hand, causes no appreciable ricosuric antagonism[2] and for his reason is preferred over aspirin n the gout patient.

This is only one of several ypes for TYLENOL®—that is, patients vho should avoid aspirin. Considering all of them, wouldn't it provide added safety (as well as added convenience) to recommend TYLENOL (acetaminophen) routinely for simple analgesia?

References: 1. Martin, E.W., et al., ed.: Hazards of Medication, Philadelphia, J.B. Lippincott Co., 1971, p. 511. **2.** Seegmiller, J.E.: Med. Clin. North Amer. 45:1259-1272 (Sept.) 1961.

Precautions and Adverse Reactions: If a rare sensitivity reaction occurs, the drug should be stopped. TYLENOL (acetaminophen) has rarely been found to produce any side effects.

Supplied: Tablets, 325 mg.
For Children:
Elixir, 120 mg./5cc. (alcohol 7%).
Drops, 60 mg./0.6cc. (alcohol 7%).
Chewable Tablets, 120 mg.

Safer than aspirin,
yet just as effective for relief
of pain and fever

Tylenol®
(acetaminophen)

McNEIL McNeil Laboratories, Inc., Fort Washington, Pa. 19034

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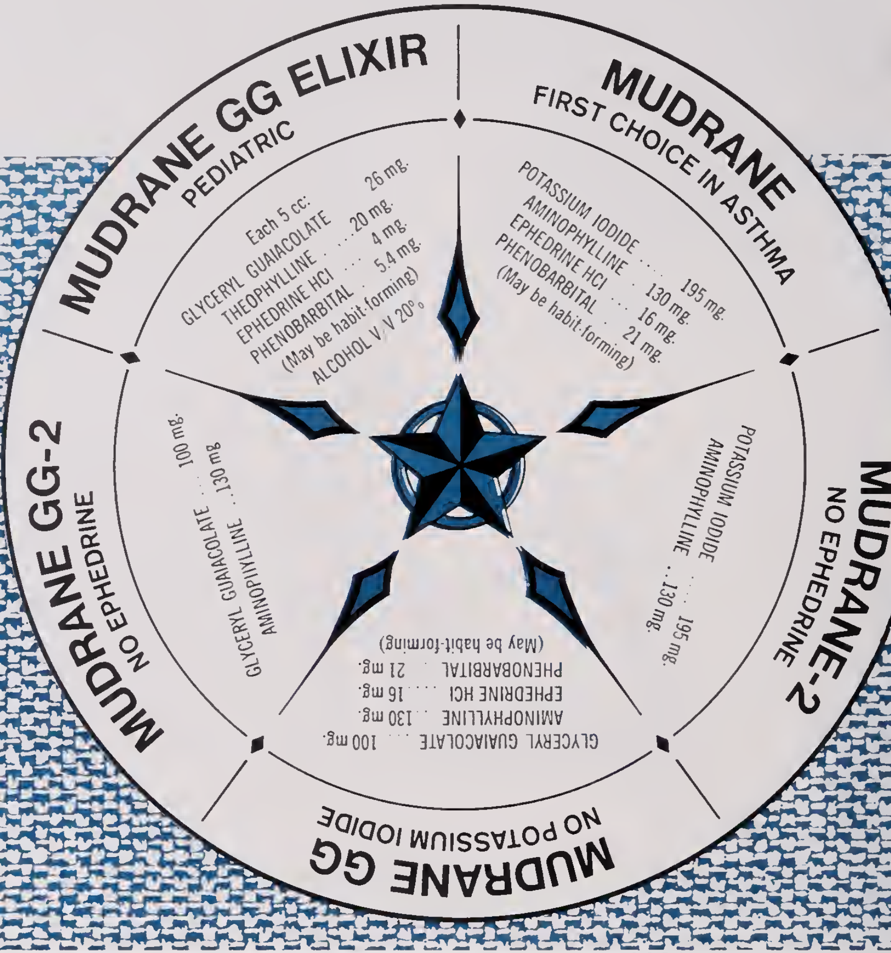
The MUDRANES

Discreet formulations of four well regarded drugs for the relief of bronchial distress—Potassium Iodide, Glyceryl Guaiacolate, Aminophylline, Ephedrine with Phenobarbital (to lessen cardiac stimulation).


MUDRANE
FIRST CHOICE IN ASTHMA
POTASSIUM IODIDE .... 195 mg.
AMINOPHYLLINE . . 130 mg.
EPHEDRINE HCl . . . 16 mg.
PHENOBARBITAL . . 21 mg.
(May be habit-forming)
MUDRANE-2
NO EPHEDRINE
POTASSIUM IODIDE .... 195 mg.
AMINOPHYLLINE . . 130 mg.
MUDRANE GG
NO POTASSIUM IODIDE
GLYCERYL GUAIACOLATE . . . 100 mg.
AMINOPHYLLINE . . 130 mg.
EPHEDRINE HCl . . . . 16 mg.
PHENOBARBITAL . . . 21 mg.
(May be habit-forming)
MUDRANE GG-2
NO EPHEDRINE
GLYCERYL GUAIACOLATE . . . 100 mg.
AMINOPHYLLINE . . 130 mg
MUDRANE GG ELIXIR
PEDIATRIC
Each 5 cc:
GLYCERYL GUAIACOLATE . . . 26 mg.
THEOPHYLLINE . . . . 20 mg.
EPHEDRINE HCl . . . 4 mg.
PHENOBARBITAL . . 5.4 mg.
(May be habit-forming)
ALCOHOL V/V 20%

INDICATIONS: For the prompt symptomatic relief of bronchial asthma, emphysema and bronchiectasis. The Mudranes dilate the bronchi and liquefy mucus plugs. DOSAGE: Tablet; One tablet with a full glass of water 3 or 4 times daily as required. Divide tablet for child's dose. Elixir; Children, 1 cc for each 10 lbs. of body weight. May be repeated 3 or 4 times a day. Adult, one tablespoonful 4 times daily. All doses should be followed with a glass of water.

CONTRAINDICATIONS: Aminophylline/Theophylline is contraindicated in the presence of severe cardiac arrhythmias and patients with massive myocardial damage. Ephedrine, in presence of severe heart disease, extreme hypertension, and in hyperthyroidism. Phenobarbital, in porphyria and in patients with known phenobarbital sensitivity. Potassium Iodide, in pregnancy (to protect the fetus against possible iodine-induced depression of thyroid activity), in tuberculosis (produces gumma dissolution), and in acne; also in the presence of known iodide sensitivity. PRECAUTIONS: Aminophylline/Theophylline should be avoided in patients with massive myocardial damage and/or severe cardiac arrhythmias. In children, overdose may cause vomiting, cardiac arrhythmias, and severe agitation. Ephedrine should be used with caution in the presence of severe cardiac disease, particularly arrhythmias and angina pectoris; avoid in hyperthyroidism and severe hypertension. Phenobarbital may be habit-forming. Avoid overdosage. Potassium Iodide: Discontinue in the presence of skin rash, swelling of the eyelids and severe frontal headache. Long use may cause goiter. ADVERSE REACTIONS: Aminophylline/Theophylline may cause nausea, cardiac arrhythmias, and aggravate severe myocardial disease. It may cause headaches and tachycardia. Vomiting and dizziness are not uncommon. Ephedrine: In patients hypersensitive to CNS stimulation, ephedrine may cause nervousness, tachycardia, extrasystole and ventricular arrhythmias. May cause urinary retention, especially in the presence of partial prostatic obstruction. Psychoneurosis may be aggravated. Pre-existing anginal pain will be aggravated. Phenobarbital may produce severe skin rash. Avoid overdosage. May be habit-forming. Potassium Iodide may cause nausea. Over very long period of use, iodides cause goiter. Discontinue if patient develops skin rash, eye irritation, eyelid swelling, or severe frontal headache.

HOW SUPPLIED: Mudrane and Mudrane GG available in bottles of 100 and 1000 tablets; Mudrane-2 and Mudrane GG-2 in 100s; Elixir in pints and half-gallons.

Federal law prohibits dispensing without prescription.

WILLIAM P. POYTHRESS & COMPANY, INC., RICHMOND, VIRGINIA 23261

Preliminary Program
117th Annual Session

MISSOURI STATE MEDICAL ASSOCIATION

Chase-Park Plaza Hotel, St. Louis April 17-20, 1975

Thursday, April 17

11:00 AM Registration of Delegates.
1:30 PM House of Delegates Meeting, opening session.
3:00 PM Reference Committee Meetings.
6:30 PM Missouri State Surgical Society Executive Council Meeting.

Friday, April 18

8:00 AM Registration.
9:00 AM General Session. *National Health Insurance.*
Introduction: James C. Cope, M.D., Columbia, MSMA President.
Speaker: To be announced.
10:30 AM Intermission to view exhibits.
10:30 AM Presiding: Jean Chapman, M.D., Cape Girardeau, President, Missouri State Allergy Association.
Participants:
Opening Remarks, Jean Chapman, M.D.
Bronchial Asthma: A Pilot Model for Diseases with Multiple Causes, Max Samter, M.D., Chicago, Ill., Professor of Medicine, Abraham Lincoln School of Medicine and Director, Institute of Allergy and Clinical Immunology, Grant Hospital.
Determination of Saliva Theophylline Concentrations in Asthmatic Children, Stephen A. Leslie, M.D., Kansas City, Fellow in Allergy and Immunology, The Children's Mercy Hospital.
Immunotherapy in Malignant Disease, Larry E. Millikan, M.D., Columbia, Associate Professor of Dermatology, University of Missouri Medical Center.
"T" Cell Deficiency (Nezaloffs)—Case Report, Donald Strominger, M.D., St. Louis, Assistant Clinical Professor of Pediatrics, Washington University School of Medicine.
The Ecology of Ragweed Pollinosis, William Solomon, M.D., Ann Arbor, Mich., Associate Professor of Internal Medicine, University of Michigan Medical School.
Sponsored by the Missouri State Allergy Association.
*11:00 AM *Nuggets of Internal Medicine.*
Participants: To be announced.
Sponsored by the Missouri Society of Internal Medicine and the American College of Physicians (Missouri Region).
*11:00 AM *Common Problems in Infectious Diseases.*
Moderator: C. Terrence Dolan, M.D., North Kansas City.
Panel Discussants:
Martin C. McHenry, M.D., Cleveland, Ohio, Head, Department of Infectious Diseases, Cleveland Clinic.
C. Terrence Dolan, M.D., N. Kansas City, Department of Pathology, N. Kansas City Memorial Hospital.
Sponsored by the Missouri Society of Pathologists, Inc.
*11:00 AM *Intestinal Bypass for Morbid Obesity.*
Moderator: George L. Tucker, M.D., St. Louis.
Panel Participants:
Gene B. Starkloff, M.D., St. Louis.
Boyd E. Terry, M.D., Columbia.
Duane Q. Hagen, M.D., St. Louis.
Sponsored by the Missouri State Surgical Society.
*11:00 AM Program to Be Sponsored by the Missouri Thoracic Society.
12:30 PM Missouri University Alumni Luncheon.
12:30 PM Missouri Society of OB-GYN and American College of Obstetricians and Gynecologists Luncheon.
12:30 PM Missouri Thoracic Society Luncheon.
* 2:00 PM Participants:
Therapeutic Approach in the Resistant Asthmatic, Hyman Chai, M.D., Denver, Colo., Director of Hospital Services, The National Asthma Center.
Rast Inhibition for Determination of Antigen Standardization, Robert J. Dockhorn, M.D., Kansas City, Chief of the Allergy-Immunology Section, The Children's Mercy Hospital.

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* Concurrent Sessions.

Clinical Standardization of Allergenic Extracts, James W. Willoughby, M.D., Kansas City, Lecturer in Medicine, University of Missouri School of Medicine.
Phagocytic Function in an Atopic Population, Christopher Gifford, M.D., Kansas City, Fellow in Allergy and Immunology, The Children's Mercy Hospital.
Round Table Discussion: The Problem Allergic Patient, Max Samter, M.D., William Solomon, M.D., Hyman Chai, M.D.
Sponsored by the Missouri State Allergy Association.

° 2:00 PM *Symposium: Coronary Artery Disease—A Continuing Controversy.*
Moderator: To be announced.
Participants:
Can It Be Prevented?, Jerome D. Cohen, M.D., St. Louis, Chief, Department of Internal Medicine, St. Louis County Hospital.
The Aggressive Plan of Management, Ben McCallister, M.D., Kansas City, Associate Professor of Medicine, University of Missouri-Kansas City.
The Conservative Plan of Management, Richard Martin, M.D., Columbia, Professor of Medicine, University of Missouri-Columbia.
Sponsored by the Missouri Society of Internal Medicine and American College of Physicians (Missouri Region).

° 2:00 PM *Program on Pediatrics.* Sponsored by the Missouri Chapter, American Academy of Pediatrics.

° 2:00 PM *Program on Psychiatry.* Sponsored by the Missouri Psychiatric Association.

° 2:00 PM *The Surgical Treatment of Breast Cancer.*
Moderator: John S. Spratt, Jr., M.D., Columbia.
Speaker: Robert Hermann, M.D., Cleveland, Ohio.
The Results of Selective, Conservative Treatment for Breast Cancer—A Ten-Year Follow-Up.
Panelist: Leslie Wise, M.D., St. Louis.
Sponsored by Missouri State Surgical Society.

3:30 PM **Intermission to view exhibits.**
4:00 PM **House of Delegates,** second session.
5:00 PM Missouri State Medical Foundation Annual Meeting.
6:00 PM **Reference Committee Meetings.**
6:00 PM Cocktails and Dinner: Missouri State Allergy Association.
6:00 PM Cocktails and Dinner: Missouri Psychiatric Association.
6:30 PM Dinner Meeting: Missouri State Surgical Society.
Speaker: Vallee L. Willman, M.D.
Trends in Surgical Education: Graduate and Postgraduate.

Saturday, April 19

8:00 AM Registration.

° 9:00 AM *Nuggets of Internal Medicine.* Sponsored by the Missouri Society of Internal Medicine and the American College of Physicians (Missouri Region).

° 9:00 AM *High Risk Pregnancy.*
Moderator: James P. Crane, M.D., Lindenwold, N. J.
Participants:
Antepartum Management—An Organized Approach, James Crane, M.D., Lindenwold, N. J.
Sonography, Jacques Sauvage, M.D., St. Louis, Associate Professor, OB-GYN, Washington University.
Fetal Scalp Sampling, Timothy O'Connor, M.D., St. Louis, Instructor, OB-GYN, St. Louis University.
Amniocentesis and Evaluation of Fetal Maturity, Manuel R. Comas, M.D., St. Louis, Associate Professor, OB-GYN, St. Louis University.
Discussion, followed by Question and Answer Period.
Sponsored by the American College of Obstetricians and Gynecologists.

° 9:00 AM *Program on Ophthalmology.* Sponsored by the Missouri Ophthalmological Society, Inc.

° 9:00 AM *Program on Physiatry.* Sponsored by Physical Medicine and Rehabilitation.

° 9:00 AM *Transplantation of the Kidney in Missouri.*
Moderator: William T. Newton, M.D., St. Louis.
Panelists: Gilbert Ross, Jr., M.D., Columbia.
Fred Whittier, M.D., Kansas City
Sponsored by the Missouri State Surgical Society.

10:30 AM **Intermission to view exhibits.**

°11:00 AM *Fiberoscopy in Diagnosis and Treatment of Cancer.*
Moderator: To be announced.
Panelists:
Rectosigmoid and Colon, Burton A. Shatz, M.D., St. Louis, Associate Professor of Medicine, Washington University School of Medicine, and Chief of Gastroenterology, Jewish Hospital of St. Louis.

° Concurrent Sessions.

Upper GI Tract and Appendages, Edward D. Kinsella, M.D., St. Louis, Clinical Associate Professor of Medicine, St. Louis University School of Medicine.
Bronchial Tract, Howard A. Andersen, M.D., Rochester, Minn., Department of Thoracic Diseases and Internal Medicine, Mayo Clinic.
Sponsored by the Missouri Division of the American Cancer Society.

*11:00 AM *Chronic Otitis Media.*
Moderator: Donald J. Joseph, M.D., Columbia.
Panel Discussants:
History and Physical Findings, Lindsay L. Pratt, M.D., St. Louis.
Radiological Findings, Joseph W. West, M.D., St. Louis.
Medical Therapy, Floyd R. Barnhill, M.D., Springfield.
Surgical Management, Michael F. Hughes, M.D., Kansas City.
Sponsored by the Missouri Ear, Nose and Throat Association, Inc.

*11:00 AM *Program on Neurology.* Sponsored by the St. Louis Neurological Sciences.

*11:00 AM *Ambulatory Gynecology—Newer Aspects.*
Moderator: Ralph E. Woods, M.D., St. Louis
Participants:
Overview and Diagnostic Uses of Laparoscopy, Ralph E. Woods, M.D., St. Louis, Associate Professor, OB-GYN, St. Louis University.
Therapeutic Uses of Laparoscopy, Ernst Friedrich, Jr., M.D., St. Louis, Associate Professor, OB-GYN, Washington University.
Colposcopy, H. Marvin Camel, M.D., St. Louis, Associate Professor, OB-GYN, Washington University.
Endometrial Sampling, Praphat Hovadhanakul, M.D., St. Louis, Assistant Professor, OB-GYN, St. Louis University.
Discussion followed by Question and Answer Period.
Sponsored by the American College of Obstetricians and Gynecologists.

12:30 PM **MSMA General Luncheon.**
12:30 PM **Fifty-Year Club Luncheon.**
12:30 PM Physical Medicine and Rehabilitation Luncheon.
12:30 PM St. Louis Neurological Sciences Luncheon.
12:30 PM Missouri State Society of Neurological Surgeons Luncheon.
12:30 PM Missouri Ophthalmological Society, Inc., Luncheon
1:30 PM *Program on Radiology.* Sponsored by the Missouri Radiological Society.

* 2:30 PM *Common Skin Diseases, Management Pearls.*
Moderator: Gordon C. Sauer, M.D., Kansas City.
Panel Participants:
Norman Asel, M.D., Columbia.
Donald Fuhrman, M.D., Kansas City.
James Sisk, M.D., St. Louis.
Wilfred Wooldridge, M.D., Springfield.
(Slides of Cases will be presented and the panel will make comments appropriate to management.)
Sponsored by the Missouri Dermatological Society.

* 2:30 PM Moderator: Ben D. McCallister, M.D., Kansas City.
Speakers:
Studies on the Objective Results of the Coronary Artery Bypass Surgery Graft Patency, Coronary Blood Flow, Survival—The Cardiologist's View, Robert Frye, M.D., Rochester, Minn., Chairman, Cardiovascular Diseases, Mayo Clinic.
Studies on the Objective Results of Coronary Artery Bypass Surgery Graft Patency, Coronary Blood Flow, Survival—the Surgeon's View, Duncan A. Killen, M.D., Kansas City, Professor of Surgery, University of Missouri-Kansas City.
Sponsored by the Missouri Heart Association, Inc.

* 2:30 PM *Presentation of Papers by Junior Fellows of the American College of Obstetricians and Gynecologists.* (Authors of outstanding papers will be presented awards.)
Sponsored by the American College of Obstetricians and Gynecologists.

* 2:30 PM *PSRO in Missouri, 1975.*
Moderator: Richard V. Bradley, M.D., St. Louis.
Panelists: To be announced.
Sponsored by the Missouri State Surgical Society.

4:00 PM **Intermission to view exhibits.**
5:00 PM St. Louis University Medical Alumni Cocktail Party.
5:00 PM Washington University Medical Alumni Cocktail Party.
5:00 PM Missouri University Medical Alumni Cocktail Party.
6:30 PM Social Hour for Those Attending Banquet.
7:15 PM **Annual Banquet in Honor of Past-Presidents.**

Sunday, April 20

7:30 AM **House of Delegates,** breakfast and final session.

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* Concurrent Sessions.

GEORGE A. ULETT, M.D., Ph.D., ***St. Lo***

Acupuncture and Medical Practice

Special Article

ACUPUNCTURE is an ancient treatment method that has newly appeared upon the U. S. medical scene. Although as yet almost universally absent from the curricula of American medical schools, it is being demanded by thousands of patients who have failed to find relief from traditional Western medical treatments. This has placed U. S. physicians in a quandary and tempted some state legislators to propose laws removing the practice of acupuncture from rational medical supervision, thus placing it in the hands of nonmedical "acupuncturists." Acupuncture has now been accepted in medical circles and hospitals in many parts of the world, and individual physicians, medical societies, schools and licensing boards in the U. S. must decide what position they will take in regard to this technique.

Many who are desirous of learning more about the subject are at a loss as to where to turn for accurate, factual data regarding acupuncture. Available books and journals devoted to acupuncture include uncritical statements and articles in which ancient principles, which are based more on philosophy than on science, serve to confuse and turn away the modern physician. Much of the current research on acupuncture is being conducted in China with reporting outside of the usual accepted channels of communication to Western physicians. Editorial policy of some American scientific journals has not been helpful because reports of clinical experience and research data from U. S. physicians interested in this subject and working in university settings have been omitted in favor of articles giving anecdotal accounts and personal opinions of physicians who, themselves, have not practiced acupuncture. A negative bias was demonstrated in the misleading title of a recent *JAMA* article entitled "Complications of Acupuncture"[1] in which one third of the cases presented were complications of moxibustion (burning of the skin from ignited herbs) rather than acupuncture and other cases illustrate primarily the perils of acupuncture performed outside of a proper medical setting.

The American public can be adequately protected from any potential dangers and complications of acupuncture only by legislation that delineates acupuncture as a part of medical practice. The majority of state boards have taken such position.[2] Reported abuses, medical complicatio and exploitation of the public have occurred those jurisdictions (nine) which permit acupur ture by nonphysicians. Even where supervision a lay acupuncturist by a licensed physician h been specified, "acupuncture mills" are flourishir The Pennsylvania Attorney General has ruled th optometrists and chiropractors cannot give ac puncture treatments.

In an attempt to place acupuncture in prop perspective, the National Institutes of Heal (NIH) has established an Ad Hoc Committee Acupuncture and granted nearly one-half milli dollars in support of university-based research pr ects on acupuncture to enlarge the fund of data ready gathered upon this subject. The first feder grant for investigation of acupuncture was given the University of Missouri, Missouri Institute Psychiatry, in St. Louis. This research proje comparing hypno-analgesia with acupuncture a algesia is in its second year and already has result in two publications. The first has substantiated t existence of the traditional acupuncture points small areas of the skin with a different measurab electrical skin potential.[3] The second paper[4] repor that stimulation of these acupuncture points ele trically demonstrated a nonspecific, presumab humorally mediated leukocytosis elicitable as w from placebo points. A presumably neurogenic r sponse of temperature elevation was seen to occ with electro-stimulation of acupuncture points, b less so with placebo points. These and other r search data, especially including significant wo from China,[5] are slowly forming a more solid scie tific base for the exploration of acupuncture's mod operandi. In recent discussions with acupuncturis from around the world, including the People's R public of China,[6] it has become evident that mo ern acupuncturists are relying less and less up ancient philosophical concepts. Explanations of ac puncture relying upon Yin and Yang and the flo of energy through the traditional meridians is bei discouraged, and the work of Dr. Chang at th Shanghai Institute of Physiology,[7] for example, permitting an explanation of acupuncture bas on modern neurophysiological concepts. The ginal spinal gate theory of Melzack and Wall,[8] ich explains the effect of acupuncture as the ret of the interaction of nervous impulses interpting the flow of pain impulses in the substantia latinosa at segmental levels in the spinal cord, s been bypassed in favor of a more acceptable planation of neural interference at the level of lamic pain receiving centers.[9]

Most of the evidence available today, including r own studies, seems to indicate that acupuncture not a phenomenon of hypnosis,[10] although like st well-publicized medical treatments, it does ry a strong element of suggestion. In China, ere acupuncture was a major treatment method turies before modern drugs became available, was understandably used for a wide variety of ditions. In rural and backward areas where er medical treatments are not available, it is still utilized. Most textbooks on the subject of acuncture are derived from centuries-old treatises d still purport the use of acupuncture for huneds of illnesses. Such use today is unsupportable, course, in the face of specific pharmaceutical and er definitive treatments that have since deloped with proven effectiveness for many of the that befall mankind. The use of acupuncture ich seemingly has the greatest clinical support lay is for the treatment of pain conditions that ve not responded to other methods of managent. Also, indeed, throughout the country and in number of leading medical centers, acupuncture used primarily in pain clinics and on patients th such problems as back pain, arthritis, headhes and causalgia. Physicians who have had nical experience with the method report a large mber of patients benefitted. These are mostly rsons who, for the most part, have been failures traditional medical and surgical approaches. It uld thus seem that acupuncture, indeed, is playg an increasingly important role in medicine toy.

In Missouri, acupuncture is being utilized by a mber of medical and osteopathic physicians pririly in the areas of Kansas City and St. Louis. e Missouri State Board of Registration for the aling Arts has taken the position that acupuncre is part of the practice of medicine and, hence, st be used only by properly licensed physicians. yet, the medical schools in Missouri have not inded courses on acupuncture in their curricula d physicians wishing to learn this technique are rced to seek training abroad or to attend lectures ven at the several traveling seminars which have ickly sprung into existence. The physician who would properly learn acupuncture must select with care since some of these seminars lack sound medical surveillance and scientific discipline and devote much of their time to teaching philosophical and ancient rituals which have little relevance to the clinical practice of modern acupuncture.

Although acupuncture is "one of today's most frequently discussed, increasingly used and least understood modalities," there is public demand for this ancient treatment method. It is the task of organized medical groups to guide state legislatures toward proper action relating to acupuncture and for medical schools to encourage research and offer opportunities for students to learn about acupuncture. Dr. Ulett is in the private practice of neuropsychiatry and Director of Neuropsychiatric Services and the Psychosomatic Research Laboratory, Deaconess Hospital. He formerly was Professor and Chairman, Missoui Institute of Psychiatry and Director, Missouri Division of Mental Health.

Initially, acupuncture was of interest primarily to anesthesiologists whose attention was drawn to the fact that numerous operations of all kinds in China have been possible under acupuncture analgesia with apparent great benefit to the patient. Acupuncture so used is similar to but probably not identical to hypno-analgesia and carries with it many of the drawbacks that prevented hypnosis from widespread acceptance as a procedure of choice by U. S. surgeons. Acupuncture produces analgesia, not anesthesia. U. S. surgeons prefer patients with relaxed musculature and who are not anxiously aware of all operating room procedures. U. S. patients typically request to be "put to sleep" and awakened only when the surgery has been completed. The most likely and promising application of acupuncture is for the relief of pain but, even here, it is usually not the treatment of choice. Rather it is best called upon when traditional methods have failed. Thus, the physician practicing acupuncture will stand as a "court of last resort" for other referring physicians.

Along with pain problems, acupuncture also has seemed to be of use in a variety of psychosomatic conditions. Although supportive psychotherapy and placebo can play a significant therapeutic role here, there is assuredly much more to acupuncture than suggestion. To paraphrase statements by such noted physicians as Professor John Bonica, Chairman of the Department of Anesthesiology, University of

Washington; Provost E. Grey Dimond of the University of Missouri-Kansas City; White House physician Walter Tkach; AMA's Morris Fishbein and others, "there is something of worth in acupuncture that merits further investigation." Certainly, much more research is required to determine where acupuncture, in the months and years ahead without a confusing mumbo-jumbo ritual, will become accepted as a useful part of medicine. Even as in 1910, it found its place in Sir William Osler's "Principles and Practice of Medicine."

In the meantime, however, the public demand for acupuncture treatment in the face of clinically demonstrated therapeutic potential cannot be ignored by practicing physicians. Acupuncture can assume its proper role, whatever that may be, in the physician's armamentarium only if licensed practitioners will take the time to learn more about this technique, not only to determine how it may be useful in their own practices but, also, to be able to properly advise their patients in regard to its use and to protect them from exploitation. Physicians have found that for one well-grounded in medical diagnosis and therapeutics and with knowledge of anatomy, acupuncture techniques are readily learned in short postgraduate courses. A number who are interested in treating painful conditions of various origin and psychosomatic conditions already have added acupuncture to their total medical armamentarium. At this time, it is the task of organized medical groups to guide state legislatures toward proper action for the incorporation of acupuncture within the practice of medicine and for medical schools to encourage research in acupuncture and to offer an opportunity for their students to familiarize themselves with one of today's most frequently discussed, increasingly used and least understood treatment modalities.

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PRESCRIBING INFORMATION

Antiminth (pyrantel pamoate) Oral Suspension

Actions. Antiminth (pyrantel pamoate) has demonstrated anthelmintic activity against *Enterobius vermicularis* (pinworm) and *Ascaris lumbricoides* (roundworm). The anthelmintic action is probably due to the neuromuscular blocking property of the drug.

Antiminth is partially absorbed after an oral dose. Plasma levels of unchanged drug are low. Peak levels (0.05-0.13μg/ml.) are reached in 1-3 hours. Quantities greater than 50% of administered drug are excreted in feces as the unchanged form, whereas only 7% or less of the dose is found in urine as the unchanged form of the drug and its metabolites.

Indications. For the treatment of ascariasis (roundworm infection) and enterobiasis (pinworm infection).

Warnings. *Usage in Pregnancy:* Reproduction studies have been performed in animals and there was no evidence of propensity for harm to the fetus. The relevance to the human is not known.

There is no experience in pregnant women who have received this drug.

Precautions. Minor transient elevations of SGOT have occurred in a small percentage of patients. Therefore, this drug should be used with caution in patients with pre-existing liver dysfunction.

Adverse Reactions. The most frequently encountered adverse reactions are related to the gastrointestinal system.

Gastrointestinal and hepatic reactions: anorexia, nausea, vomiting, gastralgia, abdominal cramps, diarrhea and tenesmus, transient elevation of SGOT.

CNS reactions: headache, dizziness, drowsiness, and insomnia. Skin reactions: rashes.

Dosage and Administration. *Children and Adults:* Antiminth Oral Suspension (50 mg. of pyrantel base/ml.) should be administered in a single dose of 11 mg. of pyrantel base per kg. of body weight (or 5 mg./lb.); maximum total dose 1 gram. This corresponds to a simplified dosage regimen of 1 cc. of Antiminth per 10 lb. of body weight. (One teaspoonful = 5 cc.)

Antiminth (pyrantel pamoate) Oral Suspension may be administered without regard to ingestion of food or time of day, and purging is not necessary prior to, during, or after therapy. It may be taken with milk or fruit juices.

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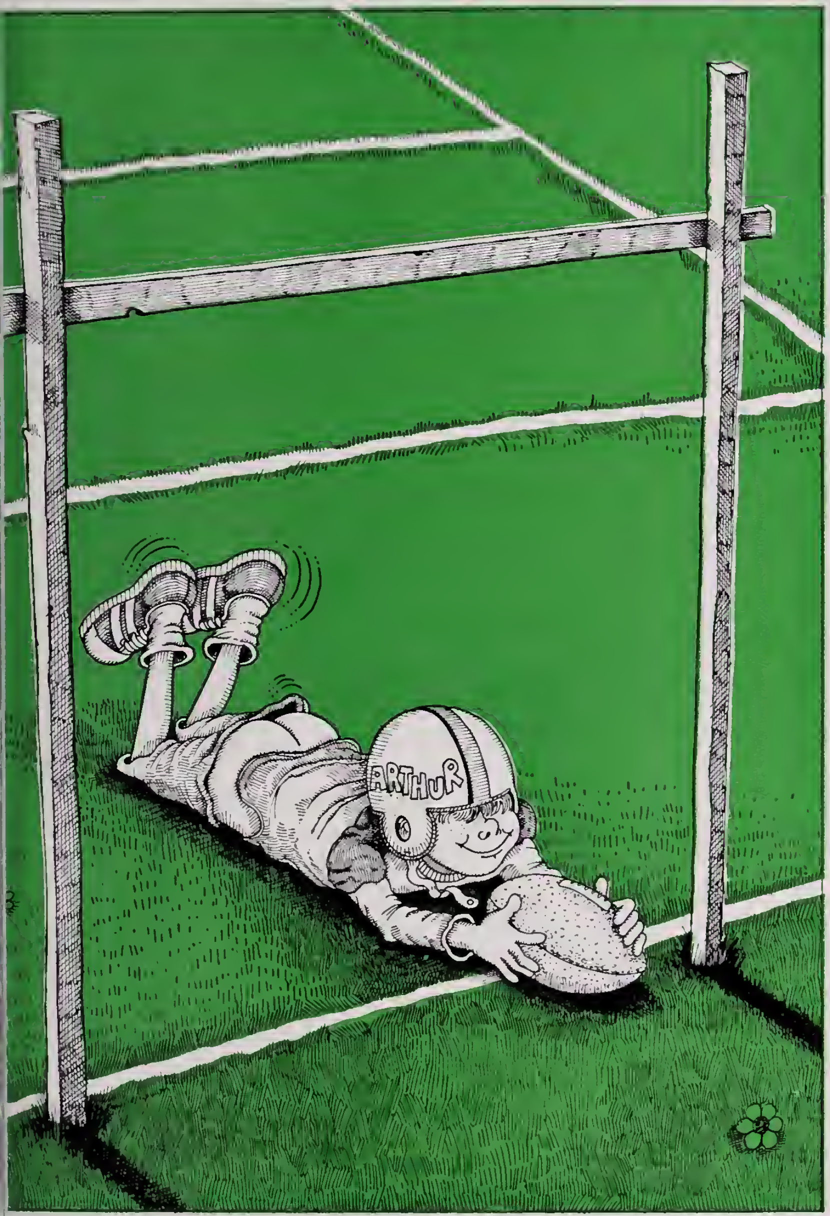

A single dose of Antiminth (1 cc. per 10 lbs. of body weight, 1 tsp./50 lbs. —maximum dose, 4 tsp.=20 cc.) offers highly effective control of *both* pinworms and roundworms.

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n Brief

summary of AMA, medical & health news

erican Medical Association / 535 North Dearborn Street / Chicago, Illinois 60610 / Phone (312) 527-1500 / TWX 910-221-0300

The AMA and other professional organizations ll cooperate in the development of a major real ate complex on four blocks adjoining the AMA adquarters. Long-range plans include a profes- nal association campus and a center for continu- ; education. The campus will be built on land ned by the AMA and the AMA Members Re- ement Plan, but neither will own any buildings the complex. The land will be leased to the ban Investment and Development Co. of Chi- go, which will plan and develop the property. e first construction is planned for mid-1975 and ll probably continue for ten years.

$30 million will be awarded by the Robert Wood nson Foundation to approximately 60 commu- y hospitals and their medical staffs to assist in ablishing primary care group practices over the xt five years. About 900 community hospitals ve received invitations to submit proposals. The ards will be announced in 1976. Every state is pected to have at least one program in which oups of three or more full-time physicians offer und-the-clock primary care for up to 15,000 ople each.

Fifty national nongovernmental organizations ll establish a National Commission on Confiden- lity of and Access to Health Care Records. The mmission will make studies and recommenda- ns, and will encourage member organizations to k legislative action. The commission grew out of conference on the subject of confidentiality, spon- red by the AMA and other groups. There, a dy group recommended that all information used PSROs be considered confidential and that ROs be exempted from state laws requiring the porting of certain health data.

Oregon and Mississippi have laws requiring the e of the AMA's uniform claim form for health surance. The Oregon law requires all third-party yers to use the form. Mississippi, where the law quires the state insurance commissioner to man- te a uniform form for all insurance companies, s opted for the AMA form. Since the form was introduced a year ago, the AMA has supplied more than three million copies. Single forms (OP-407) costing $18.50 per thousand; duplicate forms (OP-408); and continuous forms for computer use (OP-409), each costing $28 per thousand, are available from Order Dept., AMA Headquarters.

The National Cancer Institute will conduct a continuing survey of cancer data in regions with populations of 23 million. The project, costing $3.5 million a year, will help NCI determine national trends in cancer and evaluate the results of diagnosis and treatment.

53,597 medical students are enrolled in the nation's 114 medical schools this year, a 5% increase over the 50,716 reported in 1973-74. Of the total 14,763 first-year students, 22% are women. There are 1,106 black first-year students, an 8% increase over last year.

The deadline for entries in the AMA's 1974 Journalism Awards Program is Feb. 3, 1975. Cash awards of $1,000 each will be presented in the categories of magazine articles, newspaper reporting, television programs, radio programs and editorial writing. Submit entries to Journalism Awards Committee, AMA Headquarters.

Available from AMA: *Distribution of Physicians in the U. S., 1973*, a publication from the Center for Research and Development. OP-399 is available for $6 each for one to ten copies; $5.40 each for 11 to 49; and $4.80 each for 50 or more from Order Dept., AMA Headquarters. Copies mailed to foreign countries are $6.50 each. . . . Two pamphlets, "Your Blood Pressure" (OP-44) and "So You Have High Blood Pressure" (OP-202). To order OP-44—15¢ each for one to 99 copies and 7¢ each for 100 to 499 copies, or OP-202—30¢ each for one to 99 copies and 25¢ each for 100 to 499—write Order Dept., AMA Headquarters. . . . "Donation of Bodies or Organs for Transplantation and Medical Science," an AMA pamphlet. OP-371 is 30¢ each for one to 99 copies, 22¢ for 100 to 499, and 20¢ for 1,000 or more from Order Dept., AMA Headquarters.

medical melange

Notes of interest from Here . . . . and There

Dr. A. L. Hansen, Butler, has been elected chief-of-staff of the Bates County Memorial Hospital. Named as assistant chief-of-staff was **Dr. R. L. Strobach. Dr. Thomas Huffman** was elected secretary and treasurer of the group.—**Dr. H. P. Jayanandaiah** of Hannibal has been elected chief-of-staff at St. Elizabeth's Hospital by the medical and dental staff. He succeeds **Dr. J. F. Clisham** who has held the post for two terms. Also elected to staff positions are **Dr. Carl Kruse** of Palmyra as vice-chief and **Dr. Dale Burton** of Hannibal as secretary.

At a recent medical staff meeting held at the John Fitzgibbon Memorial Hos pital in Marshall, the following officers were elected: **Drs. William R. Cole**, Smith ton, president; **James A. Reid**, Marshall, vice-president; **B. F. Knipschild**, Mar shall, secretary-treasurer; **C. Alex McBurney**, Slater, delegate to the state conven tion; and **E. Lee McCorkle**, alternate delegate to the state convention.

Dr. Lois Wyatt of St. Louis was installed as president and **Dr. Charles A. Worley** of Sweet Springs was elected president-elect of the Missouri Academy of Family Physicians at the 26th annual Scientific Assembly in November, 1974.

Dr. Eugene H. Hamilton, Joplin, has retired after nearly 29 years in privat practice, first as a general practitioner and, then, as a specialist in internal medi cine during the past 21 years. Prior to moving to Joplin in 1946, he served as university physician and instructor at the University of Alabama Medical School was called to active duty in World War II in 1942, became commander of th 65th Station Hospital in Northern Australia in 1943 and was moved with hi hospital to the Philippine Islands in 1945. Dr. Hamilton is a Past-President o Jasper County Medical Society.

Thomas N. Cofer, M.D., of Chillicothe, was elected chief-of-staff at Hedrick Medical Center at its annual meeting recently. **J. B. Webber**, D.O. was elected vice chief-of-staff and **Joseph F. Gale**, M.D. was reelected as medical staff liaison to meet with the Board of Hospital Commissioners.

Dr. Arturo C. Montes, St. Louis, was installed as president of the St. Louis Academy of Family Physicians in St. Louis recently. Other newly installed officers are **Dr. Rody Ruhling**, president-elect; **Dr. P. M. Tiongson**, vice-president **Dr. Franklin P. Knight**, secretary; and **Dr. Grant Izmirlian**, treasurer. **Drs. B. C Kairuz, Charles R. Lewis** and **Leonard N. Piccione** were elected to the board o directors.

Putting out the fires of arthritic pain

Rheumatoid arthritis can sometimes spread like wildfire, with joint after joint going up inflamed: "The usual onset is manifested by spotty joint involvement but an acute onset of symmetrical polyarthritis may be noted."*

If aspirin fails, consider Butazolidin alka. Giving one capsule four times a day often provides prompt, pain-relieving, anti-inflammatory action to help restore joint mobility. The results you can get within a week can be maintained on as little as one or two capsules daily.

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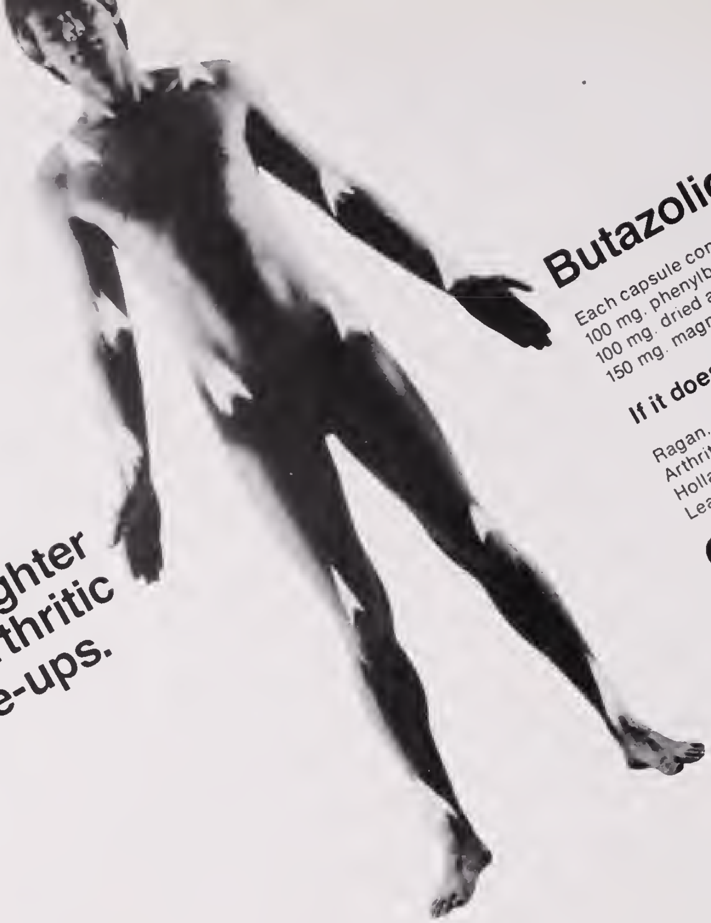

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Each capsule contains:
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Ragan, C.: The Clinical Picture of Rheumatoid Arthritis, in Arthritis, ed. 8, edited by J. L. Hollander and D. J. McCarty, Jr., Philadelphia, Lea & Febiger, 1972, chap. 21, p. 335.

Geigy

Important Note: This drug is not a simple analgesic. Do not administer casually. Carefully evaluate patients before starting treatment and keep them under close supervision. Obtain a detailed history, and complete physical and laboratory examination (complete hemogram, urinalysis, etc.) before prescribing and at frequent intervals thereafter. Carefully select patients, avoiding those responsive to routine measures, contraindicated patients or those who cannot be observed frequently. Warn patients not to exceed recommended dosage. Short-term relief of severe symptoms with the smallest possible dosage is the goal of therapy. Dosage should be taken with meals or a full glass of milk. Substitute alka capsules for tablets if dyspeptic symptoms occur. Patients should discontinue the drug and report immediately any sign of fever, sore throat, oral lesions (symptoms of blood dyscrasia), dyspepsia, epigastric pain, symptoms of anemia, black or tarry stools or other evidence of intestinal ulceration or hemorrhage, skin reactions, significant weight gain or edema. A one-week trial period is adequate. Discontinue in the absence of a favorable response. Restrict treatment periods to one week in patients over sixty.

Indications. Rheumatoid arthritis, osteoarthritis, bursitis, acute gouty arthritis and rheumatoid spondylitis.

Contraindications: Children 14 years or less; senile patients, history or symptoms of G.I. inflammation or ulceration including severe, recurrent or persistent dyspepsia, history or presence of drug allergy, blood dyscrasias, renal, hepatic or cardiac dysfunction, hypertension, thyroid disease; systemic edema, stomatitis and salivary gland enlargement due to the drug, polymyalgia rheumatica and temporal arteritis, patients receiving other potent chemotherapeutic agents, or long-term anticoagulant therapy.

Warnings. Age, weight, dosage, duration of therapy, existance of concomitant diseases, and concurrent potent chemotherapy affect incidence of toxic reactions. Carefully instruct and observe the individual patient, especially the aging (forty years and over) who have increased susceptibility to the toxicity of the drug. Use lowest effective dosage. Weigh initially unpredictable benefits against potential risk of severe, even fatal, reactions. The disease condition itself is unaltered by the drug. Use with caution in first trimester of pregnancy and in nursing mothers. Drug may appear in cord blood and breast milk. Serious, even fatal, blood dyscrasias, including aplastic anemia, may occur suddenly despite regular hemograms, and may become manifest days or weeks after cessation of drug. Any significant change in total white count, relative decrease in granulocytes, appearance of immature forms, or fall in hematocrit should signal immediate cessation of therapy and complete hematologic investigation. Unexplained bleeding involving CNS, adrenals, and G.I. tract has occurred. The drug may potentiate action of insulin, sulfonylurea, and sulfonamide-type agents. Carefully observe patients taking these agents. Nontoxic and toxic goiters and myxedema have been reported (the drug reduces iodine uptake by the thyroid). Blurred vision can be a significant toxic symptom worthy of a complete ophthalmological examination. Swelling of ankles or face in patients under sixty may be prevented by reducing dosage. If edema occurs in patients over sixty, discontinue drug.

Precautions: The following should be accomplished at regular intervals. Careful detailed history for disease being treated and detection of earliest signs of adverse reactions, complete physical examination including check of patient's weight; complete weekly (especially for the aging) or an every two week blood check, pertinent laboratory studies. Caution patients about participating in activity requiring alertness and coordination, as driving a car, etc. Cases of leukemia have been reported in patients with a history of short- and long-term therapy. The majority of these patients were over forty. Remember that arthritic-type pains can be the presenting symptom of leukemia.

Adverse Reactions. This is a potent drug, its misuse can lead to serious results. Review detailed information before beginning therapy. Ulcerative esophagitis, acute and reactivated gastric and duodenal ulcer with perforation and hemorrhage, ulceration and perforation of large bowel, occult G.I. bleeding with anemia, gastritis, epigastric pain, hematemesis, dyspepsia, nausea, vomiting and diarrhea, abdominal distention, agranulocytosis, aplastic anemia, hemolytic anemia, anemia due to blood loss including occult G.I. bleeding, thrombocytopenia, pancytopenia, leukemia, leukopenia, bone marrow depression, sodium and chloride retention, water retention and edema, plasma dilution, respiratory alkalosis, metabolic acidosis, fatal and nonfatal hepatitis (cholestasis may or may not be prominent), petechiae, purpura without thrombocytopenia, toxic pruritus, erythema nodosum, erythema multiforme, Stevens-Johnson syndrome, Lyell's syndrome (toxic necrotizing epidermolysis), exfoliative dermatitis, serum sickness, hypersensitivity angiitis (polyarteritis), anaphylactic shock, urticaria, arthralgia, fever, rashes (all allergic reactions require prompt and permanent withdrawal of the drug), proteinuria, hematuria, oliguria, anuria, renal failure with azotemia, glomerulonephritis, acute tubular necrosis, nephrotic syndrome, bilateral renal cortical necrosis, renal stones, ureteral obstruction with uric acid crystals due to uricosuric action of drug, impaired renal function, cardiac decompensation, hypertension, pericarditis, diffuse interstitial myocarditis with muscle necrosis, perivascular granulomata, aggravation of temporal arteritis in patients with polymyalgia rheumatica, optic neuritis, blurred vision, retinal hemorrhage, toxic amblyopia, retinal detachment, hearing loss, hyperglycemia, thyroid hyperplasia, toxic goiter, association of hyperthyroidism and hypothyroidism (causal relationship not established), agitation, confusional states, lethargy, CNS reactions associated with overdosage, including convulsions, euphoria, psychosis, depression, headaches, hallucinations, giddiness, vertigo, coma, hyperventilation, insomnia, ulcerative stomatitis, salivary gland enlargement.
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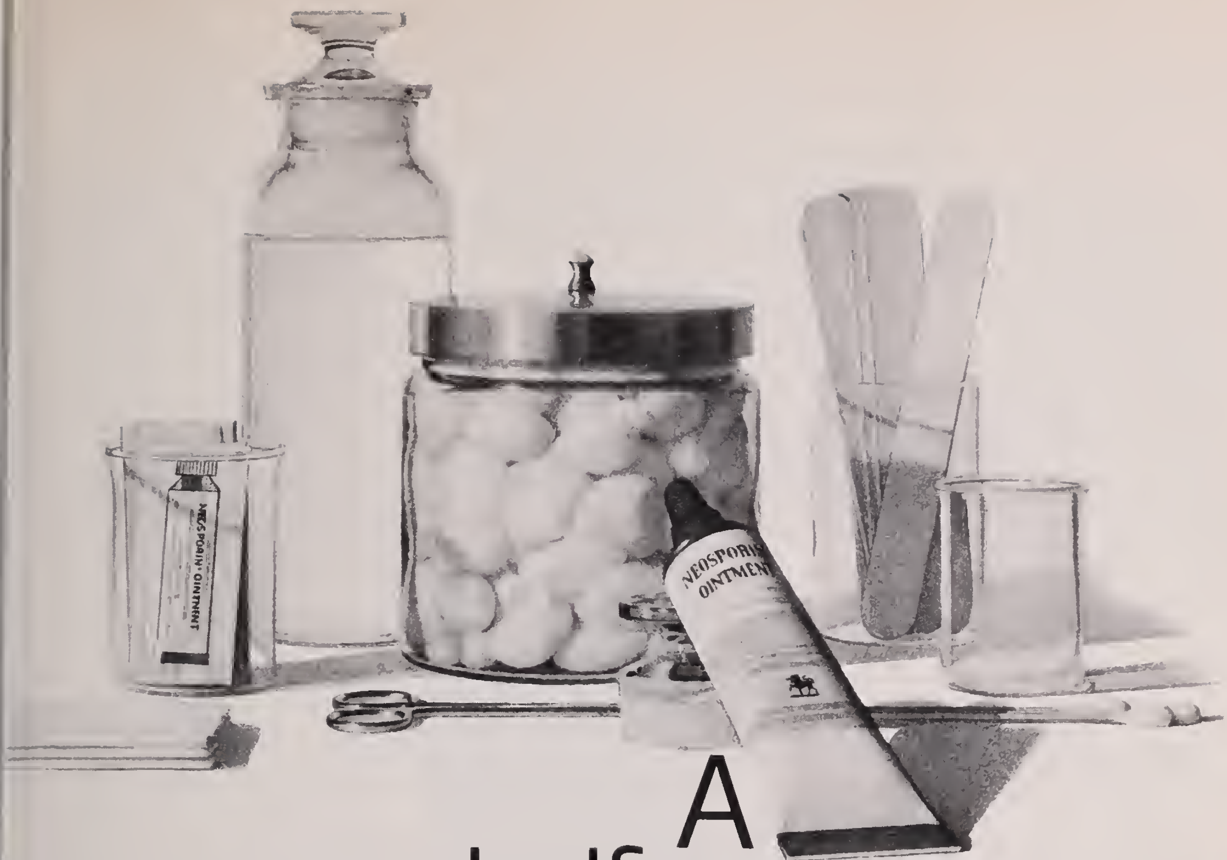

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absorption of neomycin is possible. In burns where more than 20 percent of the body surface is affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended.

PRECAUTIONS: As with other antibacterial preparations, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

ADVERSE REACTIONS: Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section).

Complete literature available on request from Professional Services Dept. PML.

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Opinion & Dialogue

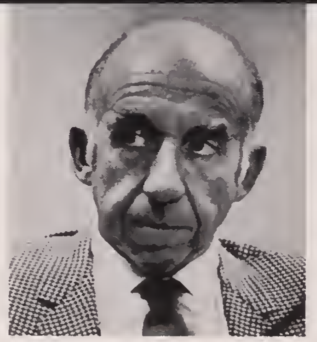
The Role of the Detail Man

Dr. Willard Gobbell
Family Physician
Encino, California

"I may be prejudiced, but I a very much in favor of the detail m I meet. Most of them are knowled able about the drugs they promot and can be a great help in acquair ing me with new medication."

Family Physician's Perception

I think that most general practitioners in this area feel as I do about the detail man. Over the years I have gotten to know most c the men who visit me regularly an they in turn have become aware o my particular interests and the nature of my practice. They, therefore, limit their discussion as muc as possible to the areas of interes to me. Since I usually see the sam representative again in future visits, it is in his best interest to supply me with the most honest, factual, as well as up-to-date information about his products.



Dr. Jeremiah Stamler
Chairman
Department of Community Health and Preventive Medicine, and Dingman Professor of Cardiology
Northwestern University Medical School

"In the total picture of deali with health problems in this coun there is a potential for detail men to play a meaningful role."

The Positive Influence

My contact with representatives and salesmen of the pharmaceutical industry is the type of co tact that people in a medical cent research people, and academic people have and that's in all likeli on a somewhat different level fro that of the practicing physician.

Let me touch on how I perso ally perceive the role of the sales representative. These men reach large numbers of health professionals. Thus they could be—and at times actually are—disseminators of useful information. They could consistently serve a real ed cational function in their ability t discuss their products.

At present they do distribut printed material, brochures and pamphlets—some of it scientifically sound and therefore truly useful—as well as some excellent fil produced by the pharmaceutical industry. When they function in t

a Source of Information?

Yes, with certain reservations.
average sales representative
great fund of information
t the drug products he is re-
sible for. He is usually able to
er most questions fully and
igently. He can also supply
nts of articles that contain a
t deal of information. Here,
exercise some caution. I usu-
ccept most of the statements
opinions that I find in the
rs and studies which come
the larger teaching facilities.
es without saying that a physi-
should also rely on other
ces for his information on
macology.

ing of Sales Representatives

Ideally, a candidate for the
ion as a sales representative
pharmaceutical company
ld be a graduate pharmacist
has a questioning mind. I don't
this is possible in every case,
so it becomes the responsibility of the pharmaceutical company to train these individuals comprehensively. It is of very great importance that the detail man's knowledge of the product he represents be constantly reviewed as well as updated. This phase of the sales representative's education should be a major responsibility of the medical department of the pharmaceutical company.

I am certain that most of these companies take special care to give their detail men a great deal of information about the products they produce—information about indications, contraindications, side effects and precautions. Yet, although most of the detail men are well informed, some, unfortunately, are not. It might be helpful if sales representatives were reassessed every few years to determine whether or not they are able to fulfill their important function. Incidentally, I feel the same way about periodic assessments of everyone in the health care field, whether they be general practitioners, surgeons or salesmen.

Value of Sampling

I personally am in favor of limited sampling. I do not use sampling in order to perform clinical testing of a drug. I feel that drug testing should rightly be left to the pharmacology researcher and to the large teaching institutions where such testing can be done in a controlled environment.

I do not use samples as a "starter dose" for my patients. I do, however, find samples of drugs to be of value in that they permit me to see what the particular medication looks like. I get to see the various forms of the particular medication at first hand, and if it is in a liquid form I take the time to taste it. In that way I am able to give my patients more complete information about the particular medications that I prescribe for them.

---

acity they are indeed useful;
icularly in the fact that they
eminate broadly based educa-
al material and serve not just
pushers" of their drugs.

Other Side of the Coin

Obviously, the pharmaceuti-
companies are not producing all
material as a labor of love—
are in the business of selling
lucts for profit. In this regard
ambitious and improperly moti-
d sales representative can
t a negative influence on the
cticing physician, both by pre-
ing a one-sided picture of his
luct, and by encouraging the
ctitioner to depend too heavily
lrugs for his total therapy. In
e ways, the salesman has often
orted objective reality and
ermined his potential role as an
cator.

Industry Responsibility

Since the detail man must be
nformation resource as well as
presentative of his particular
rmaceutical company, he
uld be carefully selected and thoroughly trained. That training, perforce, must be an ongoing one. There must be a continuing battle within and with the pharmaceutical industry for high quality not only in the selection and training of its sales representatives, but also in the development of all of its promotional and educational material.

The industry must be ready to accept constructive as well as corrective criticism from experts in the field and consumer spokesmen, and be willing to accept independent peer review. The better educated and prepared the salesman is, the more medically accurate his materials, the better off the pharmaceutical industry, health professionals and the public—*i.e.*, the patients—will be.

Physician Responsibility

The practicing physician is in constant need of up-dated information on therapeutics, including drugs. He should and does make use of drug information and answers to specific questions supplied by the pharmaceutical representative. However, that information must not be his main source of continuing education. The practitioner must keep up with what is current by making use of scientific journals, refresher courses, and information received at scientific meetings.

The practicing physician not only has the right, but has the responsibility to demand that the pharmaceutical company and its representatives supply a high level of valid and useful information. I feel certain that if such a high level is demanded by the physician as well as the public, this demand will be met by an alert and concerned pharmaceutical industry.

From my experience, my impression is that sectors of the pharmaceutical industry are indeed ethical. I challenge the industry as a whole to live up to that word in its finest sense.

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SCOTT R. RIGDEN, M.D. *and* DUANE Q. HAGEN, M.D., *St. Louis*

Psychiatric Aspects of Intestinal Bypass Surgery for Obesity

A Follow-Up Study

RIMARY PHYSICIANS are increasingly asked by moridly obese and obese patients if the jejunoleostomy ("small bowel bypass") should be conidered as optimal therapy for their condition. In urn, specialists, such as internists and psychiatrists, re increasingly asked to evaluate and recommend he propriety of this procedure. Thus, it is essential hat members of the medical profession be as well nformed as possible in regard to this relatively new rocedure; this requires data concerning the whole erson and typical responses to the procedure.

To date, the reports in the literature typically nclude demographic, medical morbidity, mortality nd weight loss data.[1] Ideally, the primary physiian or evaluating specialist should have informaion regarding the psychological and behavioral djustments these patients should expect. Oblique, ather nonspecific references to these important imensions usually are made in the literature.[1-5] oreover, although the literature for years has roduced abundant evidence regarding the moridly obese and their psychological self-image and ehavioral problems,[6-10] inclusion of a psychologial data collection is apparently not standardized rocedure. One recent exception to this trend is a aper by Solow *et al.*[11]

The goal of this pilot study is to follow longiudinally the patients who have received the jejunoeostomy with a structured questionnaire with emphasis on evaluating several dimensions, as follows: (1) demographic data, (2) medical morbidity, (3) weight loss, (4) psychological adjustment and (5) behavioral adjustment. Hopefully, practical selection criteria will be found which can help to predict what types of patients will do poorly or well after intestinal bypass operations.

Methods

Ninety-six per cent (20/21) of the patients receiving jejuno-ileostomies for morbid obesity at this midwestern medical center in the past two years were interviewed with a structured questionnaire and their charts were reviewed. The patients were interviewed for 30 to 45 minutes by one of the authors. They had been briefed beforehand by their surgeons as to the purpose of the study, and all voluntarily agreed to cooperate. The questionnaire contained a total of 24 questions randomly dealing with several categories, as follows: (1) demographic, (2) medical, (3) psychological and (4) behavioral. The questionnaire is available on request. Four surgeons performed the operations. Four patients received the standard Payne-DeWind end-to-end jejuno-ileostomy, while 17 patients received an end-to-end anastomosis involving ten inches of the jejunum and ten inches of the ileum. The patients were all at least 45 kg (100 lb) over their ideal weight and all but two were at least 125 lb overweight. They all had tried other methods of weight reduction and had failed. They also had received extensive preoperative work-ups by their internists. The authors plan to reinterview these patients annually.

RESULTS

1. *Demographic*

Eighty-five per cent (17/20) of the patients were women and 15% were men. The mean age of the women was 39.25 and of the men was 43.1 years. Fifteen per cent of the subjects were between 20 to 30 years of age, 55% were between 30 to 40 years of age, 5% were between 40 to 50 years of age, 20% were between 50 to 60 years of age and 5% were 60 years of age or older.

Educationally, 40% had finished grade school only, 35% had finished high school only, 15% had finished high school and attended some college and 10% were college graduates. In terms of being gainfully employed, 65% were employed full-time while 35% were housewives.

Thirty-five per cent of the patients had problems with unstable relationships with other important persons in their environment as manifested by their being single, separated, divorced or deserted.

Fifty per cent of the patients were six months or less postoperative while 50% were more than six months postoperative. The range of time which had transpired since the operation was three to 16 months, with a mean time of 6.5 months.

The mean weight at the time of the operation was 271 lb with a range of 210 lb to 325 lb. The mean weight at the time of the interview was 217.5 lb and the mean amount of weight loss was 50 lb with a range of 25 lb to 84 lb. The mean rate of weight loss per month was 9.3 lb per month with a range of 3.6 lb to 19.6 lb. The weight loss data are summarized in Table 1.

TABLE 1

SUMMARY OF SIGNIFICANT WEIGHT DATA

	Pounds	*Range*
1. Mean weight at time of operation	271	210-253
2. Mean weight at time of interview	217.5	157-275
3. Mean amount weight loss	50	25-84
4. Mean rate weight loss per month	9.3	3.6-19.6

In this pilot study, 21 postoperative jejunoileostomy patients are analyzed using comprehensive chart reviews and interviews based on a structured questionnaire. The routine inclusion of psychological data in the pre- and postoperative evaluation appears warranted and suggests criteria that should be helpful to physicians in practical screening of surgical candidates for this somewhat new and controversial procedure. Dr. Rigden is a Resident, Department of Family Practice, Sparrow Hospital in Lansing, Mich. Dr. Hagen is Chairman, Department of Psychiatry, St. John's Mercy Medical Center and Clinical Assistant Professor, Department of Psychiatry, St. Louis University School of Medicine.

Sixty per cent of the patients had been obese their entire lives, while 40% could pinpoint the onset of their obesity with a significant or, perhaps, stressful event in their adult lives, such as childbirth or marriage.

2. *Medical Morbidity and Mortality*

The single mortality occurred from pulmonary embolus in a 53-year-old, five-foot-seven-inch white man weighing 470 lb. Besides being the largest patient in this study, he had several concurrent medical conditions.

Four patients or 20% of the total have been readmitted to the hospital, three of them several times. The average hospital stay for the operative admission was 16 days with a range of nine to 30 days.

For the purposes of this pilot study, medical morbidity is defined as one or more of the following: (a) documented electrolyte imbalances, (b) problems requiring prolonged hospitalization or rehospitalization and (c) signs or symptoms that the patient deemed significant enough to complain about to the physician. Diarrhea will be considered in another section of the paper and is not included in this data.

In light of these criteria, 60% of the patients suffered medical morbidity. This includes 15% with hypocalcemia, 35% with hypokalemia (10% or two patients requiring rehospitalization), 5% with vitamin B_{12} deficiency and 5% with hypomagnesemia. Table 2 summarizes the 12 patients and their medical problems.

It is noteworthy that no correlation existed between medical morbidity and the type of jejunoileostomy or the quantities of food eaten postoperatively.

3. *Analysis of Behavioral Changes*

In terms of the food quantities these patients are ingesting postoperatively, 10% are even eating more than before, 30% are eating about the same amounts

TABLE 2

SUMMARY OF MEDICAL MORBIDITY

Patient	*Medical Problems*
1	a. hypocalcemia
	b. decreased vitamin B_{12}
	c. hypokalemia
2	a. dehiscence of wound
	b. amenorrhea
	c. acne
3	a. vomiting
	b. neuromuscular weakness
4	a. migratory polyarthritis
5	a. hypokalemia
	b. cardiac arrhythmia
	c. hypomagnesemia
	d. neuromuscular irritability
6	a. hypocalcemia
7	a. bladder infection
	b. edema
	c. hypokalemia
8	a. abdominal pain and cramps
	b. nausea
9	a. wound infection
10	a. hypokalemia
	b. hypocalcemia
11	a. nausea
	b. hypokalemia
12	a. hypokalemic paralysis
	b. respiratory arrest
	c. uncontrollable vomiting

nd 60% are eating less. The latter group reported at caution governed their food intake because xcessive eating invariably produced diarrhea.

The patients also were asked to compare their ostoperative activity levels with those preopera-vely. Twenty per cent reported no change, 40% re now more active and 40% are now less active. he latter group frequently mentioned fatigue and iarrhea as major limiting factors.

Fifty per cent of the patients reported no change their general levels of sexual activity, 20% are ore active in this respect and 30% are less active.

Sleeping behavior apparently was affected by is procedure. Although 65% of the patients had no ange whatsoever, 15% slept better postoperatively an before and 20% reported more difficulty sleep-g postoperatively.

Psychological Morbidity

Significant postoperative psychological morbidity is judged to be present if any of the following criteria occurred: (1) in the primary physician's judgment, the patient needed to receive antidepressants; (2) the patient has to receive postoperative psychiatric care; (3) the patient's questionnaire response indicated that he feels unhappier postoperatively than he did preoperatively. Fifty per cent of the patients do meet the above criteria. It should be noted that 20% of the total patient sample had seen a psychiatrist for therapy at some time preoperatively.

In terms of self-image, 45% of the patients felt that they were viewed or treated in a more positive manner by their peers and family postoperatively and 40% noted no change, while 15% feel they are now viewed in a more negative fashion. In rating their own appearance, 75% of the patients feel they have improved, while 25% note no change. Fifteen per cent of the patients who preoperatively felt the world to be hostile or threatening, now view the world postoperatively as basically neutral.

Regarding postoperative diarrhea and its effects on the patients, 30% have not been upset at all by the diarrhea, 20% have been moderately upset by it and 50% have been upset a great deal. This upset was usually related to rectal discomfort and extreme restriction of customary mobility, i.e., a need to be near a toilet facility.

Thirty-five per cent of the patients would strongly recommend the operation to a friend or relative, 55% would weakly recommend it with reservations and 10% would not recommend it at all.

5. *Composite Patients*

Seven patients (35%) had both significant medical and psychological morbidity. An analysis of this group gives characteristics that distinguished them from patients relatively free of postoperative problems. Tables 3 and 4 summarize the ideal and suboptimal composite patients.

These patients are not appreciably differentiated by weight loss data or time duration since the operation, i.e., greater or less than six months.

COMMENT

This pilot study indicates a 5% mortality, 60% medical morbidity and 50% psychological morbidity in our patient population. In spite of excellent care, 35% of the patients suffered both significant psychological and medical morbidity. Only 10% of the patients, however, would strongly not recommend the operation to others while the majority apparently feel that the opportunity to reduce their weight is worth considerable discomfort. Eighty-five per cent of the patients were reducing at a

TABLE 3

COMPOSITE IDEAL PATIENT

Preoperatively

1. History of stable relationships.
2. An educational background of high school, high school plus college or college.
3. Very likely juvenile obesity by history.
4. Majority have relatively stable social and psychological adjustments.
5. Even though they are morbidly obese, they tend not to deprecate their appearance extremely.
6. They consider themselves "jolly" and probably generally view the world as friendly or, at worse, neutral.
7. In the past, they have not needed psychiatric therapy.

Postoperatively

1. Decreased medical morbidity.
2. Decreased psychological morbidity.
3. More able to take diarrhea in stride.
4. Their general sexual activity level is likely to increase.
5. Their general levels of daily activities have increased.

TABLE 4

COMPOSITE SUBOPTIMAL PATIENT

Preoperatively

1. History of unstable relationships as manifested by divorce.
2. An educational background of solely grade school or grade school and some high school.
3. Majority were not overweight until a stressful event in their adulthood.
4. Majority report a history of nervousness, feeling sad, crying spells and insomnia.
5. All seemed to have especially low regard for their personal appearance.
6. They are more likely not to fit into the "jolly fat man" stereotype.
7. Seventy-five per cent of the patients in this study with previous psychiatric histories fell into this group.
8. Majority regarded the world as basically hostile or threatening.

Postoperatively

1. Increased medical morbidity.
2. Increased psychological morbidity.
3. Majority are upset "a great deal" by diarrhea.
4. Majority will not improve in their general level o sexual activity.
5. Majority are less active in their daily activities.

rate they considered satisfactory. Fifty per cent of the patients considered diarrhea to be a significant problem.

In light of the data concerning psychological morbidity, it would seem that routine inclusion of psychological data in the pre- and postoperative evaluations is warranted. This seems especially pertinent in that many patients and some physicians apparently make the unwarranted assumption that weight loss will necessarily lead to a solution of the patient's concomitant emotional and psychological problems.

The study suggests criteria that may be helpful for practical screening of surgical candidates. In addition, the study includes demographic data that delineate what segments of the morbidly obese population are seeking this still somewhat new and controversial procedure.

The study can readily be criticized on the grounds of needing more patients, needing longer follow-up and the lack of a control group of morbidly obese patients undergoing some kind of other surgical procedure.

In recommending a patient for this operation, the physician has to balance the risks of severe, chronic obesity against operative risks and potential long-term complications of the intestinal bypass procedure. Certainly, patients undergoing the procedure should have as complete information as possible as to what they should realistically expect. Therefore, it is felt that the few questions this study answers and the many it raises must be thoroughly considered by all physicians involved with the morbidly obese patient.

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JOHN S. SPRATT, JR., M.D., M.S.P.H., ***Columbia***

Cancer Control Program Planning for Missouri

About 53,000,000 Americans now living will eventually have cancer. This means one in four persons according to present rates. Cancer will strike over the years in approximately two of three families. In the 70s, there will be an estimated 3.5 million cancer deaths, 6.5 million new cancer cases and ten million persons under medical care for cancer. Projected to Missouri, the estimate can be made that in the 70s, there will be 17,000 to 18,000 new cancer cases per year and 8,000 to 9,000 cancer deaths per year.

For more than 35 years since 1936, the cancer death rate has been declining slowly but steadily among American women for a drop of 8%. During the same period, the male rate has increased about 40% and it is particularly higher among blacks. The decline among women is traceable to a sharp reduction in mortality from cancer of the uterine cervix, a readily detectable disease. The rise among men is due to a 1,400% increase in 40 years from ung cancer. Since 1949, more men than women have been dying each year from cancer; the ratio in 1974 was about 54 to 46. The incidence rate among men also has increased from 280 in 1947 to 304 per 100,000 persons in 1969, while the rate among women was decreasing from 294 to 256. The higher male incidence is attributed to a marked increase in cancer of the prostate, as well as lung, and to a lesser increase of colon cancer. The decrease among women has been aided by a drop in cancers of the stomach and rectum as well as cervix, but lung cancer in women rose from 6% to 12% per 100,000 between 1947 and 1969. The incidence of cancer in blacks is markedly higher than in whites, particularly among men. Black men show onsiderably higher rates for cancers of the prostate nd esophagus. Black women have a higher rate of ervix cancer and lower rates of breast and uterus ancers. Death by age groupings shows more than alf of all mortality among persons over 65. Among women, 32 to 54 years of age, cancer is the leading ause of death, and more school children die of ancer than any other disease. This year, cancer will take the lives of approximately 3,500-plus hildren under the age of 15 and about half of them will die of acute leukemia.[1]

There are to date no complete figures on the economic effect of cancer in this country. Some estimates of the cost of illness can be made, using the 1963 figures established in the Health Economics series number six compiled by the United States Department of Health, Education and Welfare. Estimates from these figures can be adjusted to reflect the increases in the cost of medical services, earnings and number of cancer patients. According to these estimates, the direct cost for hospitalization, nursing homes, physicians, nurses and medicines exceeded $1.5 billion in 1969.[2] Some calculated that the indirect cost of cancer (including the loss of earnings during illness and present worth of loss of earnings during the balance of normal life expectancy) brought the total cost of cancer to more than $15 billion for 1969. "1973 Facts & Figures," produced by the American Cancer Society, cites a 1962 report reflecting cancer illness among those under 65 years of age as costing 72,000 man-years of productivity among the labor force, 44,000 man-years among those keeping house and 52,000 man-years among those unable to work. Among women, cancer far exceeds any other disease as a cause of "working years lost"; among men, it is the third after accidents and heart disease. Lung cancer and emphysema, another chronic lung disease caused mainly by cigarette smoking, may be the prime disablers of working men between

For more than two decades, the cancer death rate has been increasing. The overall objective of the Cancer Control Program is to plan, establish and evaluate a statewide program to better serve Missourians in the prevention, detection and treatment of cancer and the rehabilitation of cancer patients. An appropriate blend of state and federal activity will provide maximum momentum needed to cope with cancer problems in the state. Mr. Thomas is Assistant Director for Cancer Control, Missouri State Cancer Control Program. Dr. Spratt is Director, Cancer Research Center.

ages 40 and 65. Emphysema now ranks second to heart disease in that respect; as a killer, it increased its U. S. death toll 700% between 1950 and 1965.[3]

The top four killers in Missouri, heart disease, cancer, stroke and accidents, have held their positions statewide since 1949 and in the United States since as far back as 1939. Malignant neoplasms, including cancer of the lymph system and blood forming tissues, killed 8,682 state residents to rank as 1971's second leading cause of death. This means that almost 182 of every 100,000 Missourians died of cancer during 1971. Cancer was among the five leading killers for all ages except persons less than one year old. More people in the 35 to 44 age group in Missouri died of cancer than from any cause and, more frequently, from cancer attacking the respiratory system.[4] The estimated cancer deaths and new cancer cases for all sites plus major sites for 1974 are as follows: The estimated cancer deaths in Missouri in 1974 for all sites will approximate 8,900 with the rate per 100,000 population being 184. Of the major sites, we can anticipate 2,100 deaths from lung cancer, 1,200 from cancer of the colon and rectum, 800 from breast cancer, 550 from prostate cancer, 475 from pancreatic cancer, 400 from leukemia, 275 from stomach cancer and 175 from oral cancer. Estimated new cancer cases in Missouri for all sites approximate 16,000 for 1974. The breakdown on major sites of estimated new cancer cases are as follows: New cases of colon and rectum cancer, 2,500; lung, 2,300; breast, 2,200; prostate, 1,700; uterine, 1,200; leukemia, 550; pancreas, 500; oral, 500; and estimated new cases of stomach cancer will approximate 450.[1]

For more than two decades, the cancer death rate has been increasing. For the United States, the rate has increased from about 140 per 100,000 persons in 1950 to more than 160 in 1970. During the same period, the cancer death rate in Missouri is approximately 14% higher than the cancer death rate in the United States.

In part, the reasons for this increase may be explained by the fact that people are living longer. The higher cancer death rate in Missouri may be accounted for, in part, by the generally older population of Missouri compared with the rest of the country. Also, it is believed that, in part, the greater cancer death rate may be attributed to the increased exposure of the population to more cancer producing agents in the environment.[5]

By agreement between the Board of Health and the Cancer Commission, the Commission has taken responsibility for all cancer control activities in Missouri and has asked a senior staff member at the Ellis Fischel State Cancer Hospital to serve as Program Coordinator for Cancer Control. Detailed planning is now taking place to insure maximum utilization of existing resources in disease treatment programs and other collateral public health programs in the state of Missouri. The overall objective of the cancer program is to plan, establish and evaluate a statewide program to better serve Missourians in the prevention, detection, treatment and rehabilitation of cancer. The Cancer Control Program is still in its planning stages, but a Phase I survey has been completed.

This survey was intended to identify existing cancer control programs in other states and to assess cancer related needs in Missouri as perceived by physicians, personnel of the Division of Health, former patients of Ellis Fischel State Cancer Hospital and volunteers of the Missouri Division of th American Cancer Society.

The survey of cancer control activity in othe states was intended to profile typical organizationa patterns and component activities. Survey questionnaires went to the 50 United States, Guam an Puerto Rico. Of 47 questionnaires returned, 22 in dicated an organized cancer control activity. Th typical organizational pattern is as follows:

	%
Funds from State Government	36.
Funds from Federal Government	36.
Funds from both State and Federal Sources	31.
Support from State Division of Health	27.
Association with Regional Medical Program (RMP)	27.
Association with Comprehensive Health Planning (CHP)	18.
Association with both RMP and CHP	13.
Association with a State Medical Association	13.
Support from a Division of American Cancer Society	6.
Association with a State Hospital Association	4.

And, the component activity pattern was a follows:

	%
Operational Cancer Registry	63.
Cancer Prevention Activity	40.
Cervical Screening Activity	27.
Public Education and/or Information Activity	27.
Continuing Professional Education Activity	27.
Cancer Detection Centers and/or Programs	27.
Diagnostic/Treatment Activity	13
Rehabilitation Activity	4

A second survey was sent to 165 hospitals in Mi souri to identify areas of strength or weakness both in services, educational programs for canc patients, programs on cancer for the hospital sta and rehabilitation facilities available to the vario

TABLE 1

	Weekly	*Monthly*	*Quarterly*	*Annually*	*No Program*
Physicians	11	10	6	14	29
Registered nurses	5	8	12	21	29
L.P.N.'s	4	5	14	20	30
Nurses aides	2	6	13	17	33
Lab technicians	2	6	3	7	42
Therapists, speech, rehab., etc.	5	3	0	6	43
Social workers	4	5	1	4	38

TABLE 2

	Rehabilitation		*Education*	
Head and neck	16 Yes	22 No	22 Yes	57 No
Breast	24 Yes	55 No	29 Yes	50 No
Extremities	21 Yes	59 No	25 Yes	55 No
Rectal and colon	19 Yes	59 No	25 Yes	54 No
Genitourinary	15 Yes	62 No	21 Yes	57 No
Nervous system	16 Yes	62 No	22 Yes	57 No

categories of cancer patients. Summarization of the hospital survey questionnaires reflects areas of strength and areas of gross inadequacy. An obvious inadequacy detected from the 89 responses currently summarized is the fact that rehabilitation services or programs or both available for the various categories of cancer patients are minimal and poorly distributed.

Two examples relate to rehabilitation and education. Table 1 represents responses to this question: "How often are professional educational programs offered to help the hospital staff understand the various types of cancer and better work with the cancer patient?"

Table 2 represents responses to this question: "Does your hospital have rehabilitation facilities or educational programs or both for the following types of cancer patients?"

These and other responses charted by Regional Planning Commissions identify areas for program planning which will be most appropriate to the expressed needs.

One of the program planning objectives for the Missouri program is to develop appropriate mechanisms to acquire federal funding which complements ongoing state and private activity. To date, the National Cancer Institute's Cancer Control Program has developed more slowly than expected. Several things have contributed to the slow rate at which the program is being developed. Among these are (1) the fact that HEW's health arm has been operating under a continuing resolution, meaning that it is funded at the same budgetary level as the previous year; (2) the health branch is still in the midst of reorganization; and (3) contracts for specific pieces of research or program activity are being utilized more often as the primary mechanism for project development as opposed to the traditional grant. This means the State Cancer Control Program can identify specific cancer program needs in the state and develop an appropriate grant for submission, but has no assurance that National Cancer Institute contracts for project development will relate to identified needs. The ability to respond to the several contracts available has been inadequate due to stringent contract requirements, limited State Cancer Control Program staff and an extremely limited time frame allowed for contract development and response.

Initiative and commitment at both the state and community levels will definitely be required to develop a substantial cancer control program for Missouri which can be responsive to identified state needs and make maximum utilization of federal cancer control program initiatives and funding. With an appropriate blend of state and federal activities, maximum momentum can be developed and appropriately directed to cope with cancer problems in Missouri.

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and* DOUGLAS HUEWE, M.D., *Springfield

Treatment of Skin Cancer by Cryosurgery

The perfection of technical equipment has made available the new, highly successful cryosurgical treatment of basal and squamous carcinomas of the skin and orifices. Its valuable addition to the other classical methods enables the therapist to individualize treatment and to be of the greatest overall service in the treatment of skin cancer. This paper follows in pattern Dr. Wooldridge's remarks on the same subject on the Guest Lecture Series at New York University in April, 1973. The authors are in the private practice of dermatology. Dr. Wooldridge also is a Clinical Professor of Dermatology, University of Missouri-Columbia School of Medicine.

Because of their accessibility, basal and squamous carcinomas of the skin and orifices are treated by many methods. The classical treatments have been by excisional surgery, by electrosurgery and curettage and by radiotherapy. A few years ago, the technique of Moh's chemosurgery was added to these. This choice of modalities has been a great advantage to the experienced therapist because it has enabled treatment to be individualized in consideration of the site, size and type of lesion, with the physical condition and age of the patient.

Now, a new approach has been added. The perfection of technical equipment has made available a highly successful cryosurgical treatment, therapy utilizing cold.

The use of cold in tumor therapy is not new. The first publication on this subject appeared in 1899.[1] The problem at that time was not lack of appreciation of the effects of freezing of tissue but, rather, lack of easily available freezing agents and, even more, of equipment to utilize those agents effectively. Because of this difficulty in handling liquid nitrogen and liquid air, these materials were applied only to the skin and only with cotton-tipped applicators. The inefficiency of the ordinary applicator of this type meant that only very superficial freezing was possible. Actinic and seborrheic keratoses responded nicely to this treatment and are still treated in this way, but this is not adequate treatment for more deeply penetrating lesions.

In the last 15 years, several investigators studied the cellular and intercellular effects of cold and devised more efficient ways of utilizing it so that tissue could be frozen to a depth of several millimeters.[2-7] Equally important, methods were developed so that the degree and duration of freezing of tissue could be accurately monitored. This permitted more exact procedures. At the time of perfection of the techniques for skin treatment, other techniques were developed for treatment of brain, prostate and uterine cervical lesions. Two basic types of equipment were marketed for skin treatment. The first was a closed system which could be utilized with pressure probes. The second apparatus utilized a spray of liquid air or nitrogen (nitrogen is customarily used). By projecting a jet of mixed gaseous and liquid nitrogen onto a skin surface at a temperature of –196 C, tissue is rapidly frozen with the formation of intracellular and intercellular ice crystals. Irreversible cell damage occurs when a temperature of –20 C is reached. The extent of cellular damage becomes even greater with refreezing and longer freezing.

Method

In our own work, we have found that the more simple, trouble-free and less cumbersome spray apparatus is highly satisfactory (Fig. 1). This equipment has been modified recently so that freezing also can be accomplished with pressure probes as well as spray. As yet, however, we have seldom employed the probes.

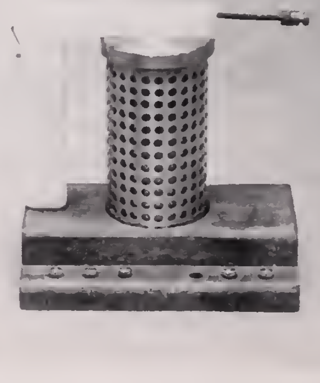


Fig. 1 Cryosurgical spray equipment, with attached aperture seated in its stand. Inserted in base *(foreground)* is a row of interchangable nozzles of varying apertures.

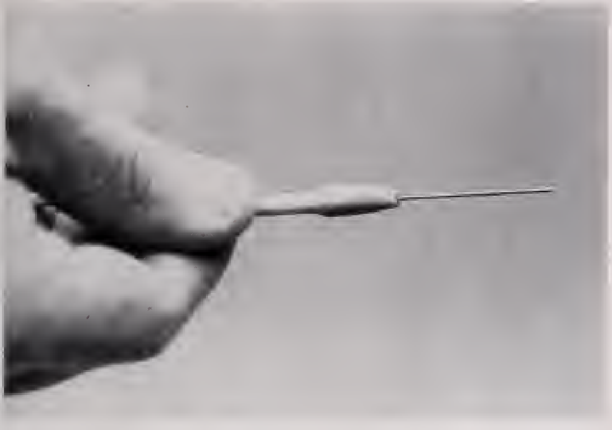


Fig. 2 Microthermocouple. The 2 mm temperature sensitive tip is inserted beneath the skin cancer.

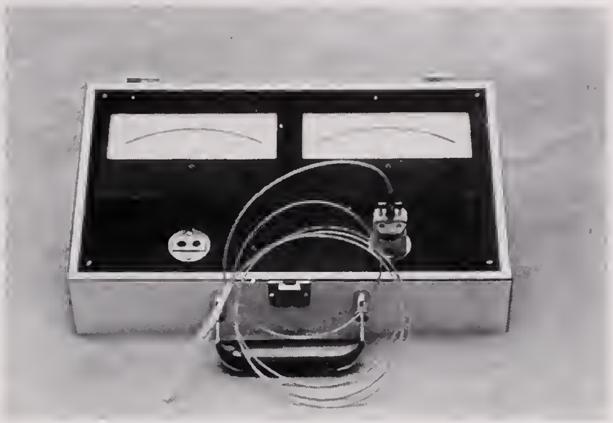


Fig. 3 Pyrometer (temperature indicator) with one attached microthermocouple.

To ascertain the extent of tissue freezing, we always note the "thaw time." This is the time required for the visual disappearance of ice crystals from the treated area. The "thaw time" becomes longer with the increasing bulk of tissue frozen and, also, becomes longer in areas where the vasculature is not so extensive and efficient. For this reason, the "thaw time" is considerably longer on the hand than on the face, all other factors being equal.

In spite of the information obtained by the "thaw time," we depend more on the readings made possible by the use of the microthermocouple (Fig. 2). This instrument is constructed in a #20 needle. Smaller calibers are available for use in tedious sites such as the eyelid. The microthermocouples are constructed so that the temperature-sensitive tip is inserted through a peripheral bleb of anesthetic and beneath what is believed to be the area of deepest invasion of the lesion. The thermocouple is then connected to a temperature indicator (pyrometer) so that the temperature can be read directly (Fig. 3). If a lesion is large, it may be mapped into segments with a separate thermocouple for each area. In this way, a large lesion can be treated one segment at a time. This facilitates a more uniform freezing throughout its entire extent.

From the first, we somewhat arbitrarily selected a technique of freezing tissue to a level of −30 C and using two freeze cycles. After the first cycle, we allowed thawing to 0 C. The tissue was then immediately refrozen. Our thinking was that by freezing to −30 C, we could be more certain that every area of the field reached at least the critical temperature of −20 C. This minimized the likelihood of insufficient treatment at the periphery of a lesion. The second freeze was used because experimental data suggested that cell death was achieved with greater certainty with a second cycle.

Tissue Reaction to Freezing

The immediate reaction of the skin to freezing of this degree is erythema accompanied by a moderate degree of pain and burning sensation. The pain is not severe enough to require analgesics unless several areas or an exceptionally large area is to be treated. This discomfort lasts only briefly and is followed by a dull ache. The erythema persists and is quickly followed by pronounced edema and blistering. This accumulation and exudation of fluid occurs as a result of endothelial damage and resultant vessel permeability. The edema can become very prominent in periorbital areas and may take several days to subside. This immediate reaction causes vascular stasis and thrombosis in the microvessels of the skin[5] which results in tissue necrosis. The time for healing varies directly with the diameter of the area frozen. This is usually three to four weeks for a 2 cm area. Approximately one additional week for each additional centimeter diameter is required. Healing time is longer for the extremities than about the head and neck. Treatment is entirely an office procedure and does not ordinarily interfere with work or household duties.

Patient Clinical Study

We now have a five-year experience in the cryosurgical treatment of basal, basosquamous and squamous skin cancers. A total of 1,162 such lesions were treated by the end of 1973. Of these, there were 859 basal cell, 39 basosquamous and 264 squamous cell lesions. All of these were histologically confirmed.

Only a very few of these cancers measured less than 10 mm in diameter. The majority measured between 10 mm and 25 mm and a considerable number more than 50 mm. Ninety percent of these occurred about the head and neck. There were several patients with multiple superficial carcinomas on the back. A few basal cell lesions were found on the extremities and a small number of squamous lesions on the backs of the hands.

As might be expected, the ages of these patients peaked at the seventh and eighth decades with some being older but with a surprising number being younger. The youngest was 24 years old. Although solar exposure did not seem as obvious a provoking factor in the basal as in the squamous carcinomas, it seemed a fairly constant and frequent etiologic factor throughout.

Clinical Experience

Since cryosurgical treatment of such skin cancers is still being evaluated, we have been in a favorable position because of our considerable flow of suitable patients. In order to arrive at sound conclusions as rapidly as possible, we adopted a single technique of freezing, as described above, and all patients have been treated in this manner. For follow-up, we see our patients at three weeks, then at four, 12, 18 and 24 months after treatment. We realize this is not a sufficiently long follow-up for systemic malignancies, but the detailed, exhaustive studies of Ebenius[8] and Magnusson[9] have established the two-year period as long enough for cancers of the skin and lip (excluding melanomas). Throughout this series, we have yet to see a recurrence after two years. While these undoubtedly occur, they must be a very small and statistically insignificant number.

Our patients come from a relatively small geographic area, which simplifies follow-up. It also is our practice to carefully indoctrinate patients in the importance of these post-treatment visits. Table 1 summarizes our experience with patients with 606 lesions which were treated between March 1, 1969 and Dec. 31, 1971.

On the basis of the completely followed patients covered in Table 1, the 19 recurrences constitute an overall 3.1%. This figure compares favorably with the results of other treatment. Many of these recurrences were found among patients treated early in the series when we were perfecting our technique.

TABLE 1

Number of Lesions		*Number of Lesions Followed Two Years*	*Number of Known Recurrences*
Basal cell	438	364	13
Squamous cell	144	116	5
Basosquamous cell	24	17	1

It also should be noted that many of the lesions treated were already recurrent after various sorts of prior treatment and that the lesions were among the largest we see.

In the group of 116 squamous cell lesions which were followed for two years, there were 27 lip cancers. Each of these was too large for simple V-excision. The largest measured 44 mm. In this group, we have experienced only a single recurrence and no regional metastases.

Discussion

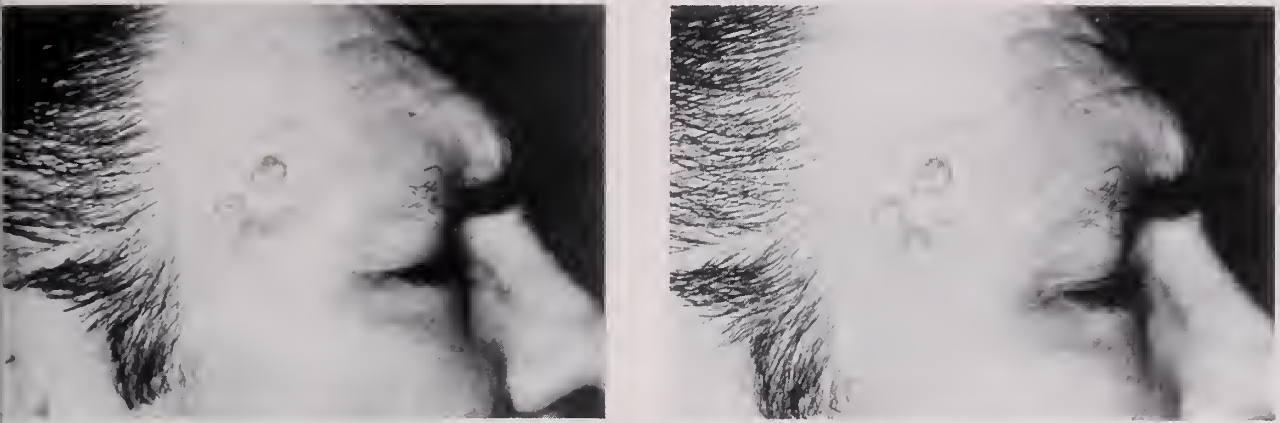
Before the use of cryosurgery for skin and orificial cancer, we treated one third of our lesions with electrodesiccation and curettage, one third by excision and one third by our technique of combined radiation with superficial x-ray and gamma radium sources.[10-13] As our experience with cryosurgery has increased and our technique has improved, we have increasingly adopted this method. We now continue to treat one third of such lesions with electrodesiccation and curettage, but these are generally less than 10 mm in diameter and present no particular invasive or cosmetic problems. This simple method, when properly employed, is highly effective, inexpensive and free of complications. For those lesions which are small but which do present cosmetic problems, we employ excisional surgery. We now treat about 15% of cancers in this way.

However, with cryosurgery now available, we have reduced the number of lesions we treat radiologically to about 5% of the total. Because of the reliability of our radiological technique for use in such difficult sites as the canthi of the eyelids, we prefer to treat these lesions in this manner. We also prefer this approach for the deeply invasive lesions we find in the nasolabial and postauricular folds because we can achieve such a satisfactory depth dose of radiation with a relative sparing of surface tissues. We find that many of our patients referred to us with recurrent carcinomas have lesions in these sites. This leaves about 50% of our lesions which we now prefer to treat cryosurgically.

Therefore, with these explanatory remarks, let us enumerate what we consider to be the advantages and disadvantages of cryosurgical treatment of these lesions.

Advantages:

1. Simplicity of technique. This treatment is easily learned. It can be completed at a single visit and with minimal expenditure of the physician's time and the patients' money. Hospitalization



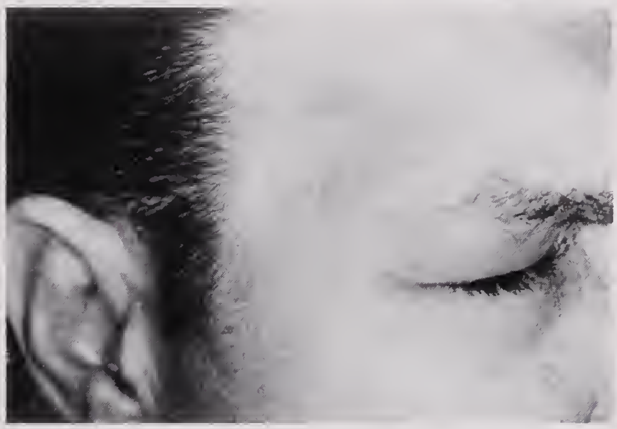


Fig. 4 *(Above)* **Basal cell carcinoma recurrent after three attempts with electrodesiccation.** *(Top, right)* **Same lesion outlined to show visible margins of lesion.** *(Right)* **Site two years after cryosurgical treatment.**

s not necessary, and only for those patients with very large lesions is there interruption with patient occupation.

2. It is possible to treat multiple lesions at the same office visit. This is often necessary with our ocal sun-exposed, sun-sensitive Anglo-Saxon population.

3. There is minimal scarring (Figs. 4, 5 and 6). The cryosurgical scar is mainly evident as a partially depigmented area, which is soft, servicable and pliable. Any tendency to hypertrophic scarring s temporary. There is no formation of keloids. The appearance of the scar improves with time. There s nothing to resemble the late radionecrosis, which s a hazard after even the most skillfully administered cancericidal dose of radiation.

4. In the event of recurrence of basal or squamous skin cancer after cryosurgery, it is possible to etreat the area with cryosurgery. Our recurrences eported in the 1969-1971 series have often been at he edge of the treatment field when sizable lesions vere treated in this way. Until our experience was ufficient and our technique perfected, we did not realize that our microthermocouple inserted beneath the center of a lesion may indicate only adequate freezing of that immediate area with insufficient freezing of the periphery of the lesion. As described previously, we overcame this problem by dividing a large field into segments and treating each segment separately with its own microthermocouple. This lends to more uniform freezing of the entire field. We already have found that this approach will reduce our recurrence rate.

5. Tumor recurrence in sites previously treated with radiation may be nicely retreated with cryosurgery. This was a gratifying discovery because

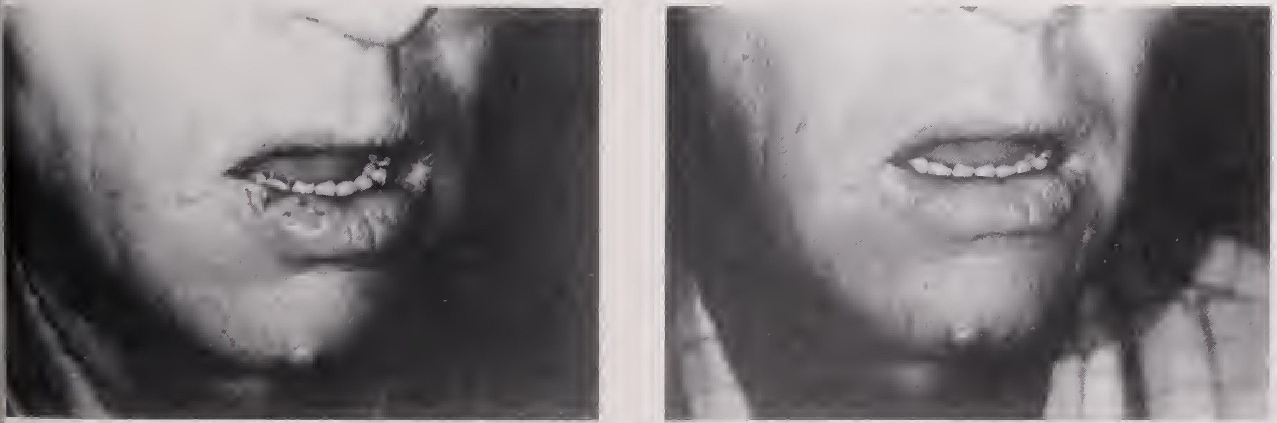


Fig. 5 *(Left)* **Untreated 18 mm carcinoma of lip.** *(Right)* **Site two years after cryosurgical treatment.**

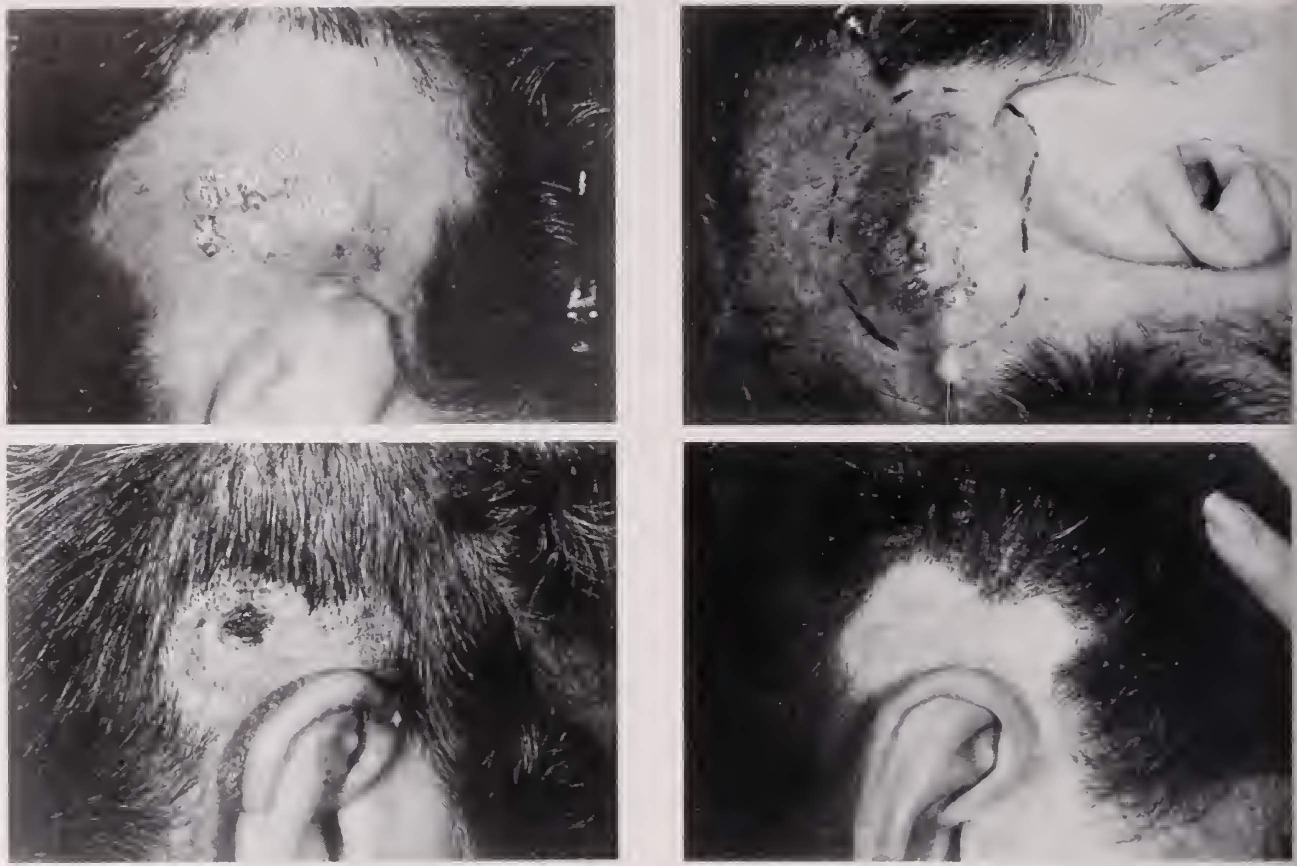


Fig. 6 *(Top, left)* Untreated basal cell carcinoma of parietal area of scalp. *(Top, right)* Patient recumbent with area to be frozen outlined and two microthermocouples inserted beneath lesion. *(Bottom, left)* Site four weeks posttreatment. *(Bottom, right)* Site two years posttreatment illustrating the loss of hair following freezing of this degree. Sebaceous and sweat glands are lost, also.

areas of radiodermatitis usually cannot be treated again with a cancericidal dose of radiation without prohibitive risk of necrosis. Also, previously irradiated skin is always a difficult surgical site. Therefore, to find that cryosurgery could be used without risk of tissue breakdown was good news, indeed. We have treated such areas with cryosurgery on several occasions and we have never yet provoked a nonhealing wound.

Disadvantages:

1. A certain amount of pain accompanies and immediately follows treatment. This is not a major obstacle and does not require the use of analgesics. During the freezing, we do not anesthetize the area because we do not wish to place extraneous fluid in the field which might interfere.

2. There is difficulty in attaining homogenous freezing throughout a large field. This was a problem early in our experience. As explained above, we believe the problem has been solved.

3. There is only a certain depth of freezing which is practical with either sprays or with pressure probes. Beyond that limitation looms the likelihood of massive necrosis of surface tissue. Therefore, as previously explained, areas such as the nasolabial fold and postauricular fold, where lesions tend to extend deeply along the planes of dermal tissue lying at right angles to the surface, cryosurgical treatment is probably not the first choice because of insufficient deep freezing. Here, we continue to prefer our treatment with x-ray and interstitial implantation of gamma radium sources to insure proper depth dose.

4. The "persistent nodule." Occasionally and quite unpredictably, there will be an irregular, rough plaque remaining when the inflammatory reaction subsides following treatment (Fig. 7). Early in our series, we were concerned that this represented tumor persistence. A few biopsies calmed our fears because it was quickly found that the plaque represented the edematous stroma of the tumor. When the tumor cells were destroyed by treatment, this plaque spontaneously disappeared after a few months. This "persistent nodule"

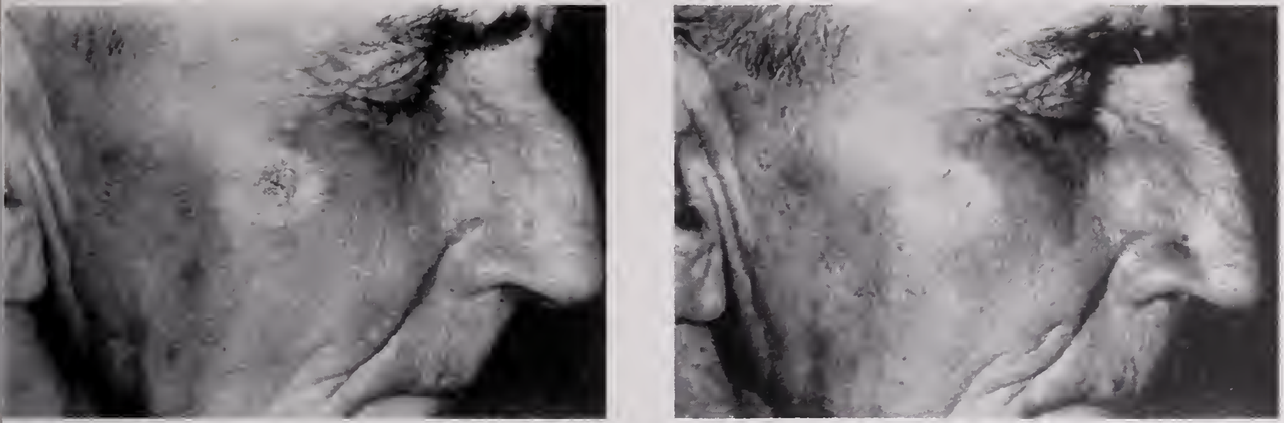


Fig. 7 *(Left)* "Persistent nodule" two months posttreatment. *(Right)* Disappearance of nodule six months posttreatment.

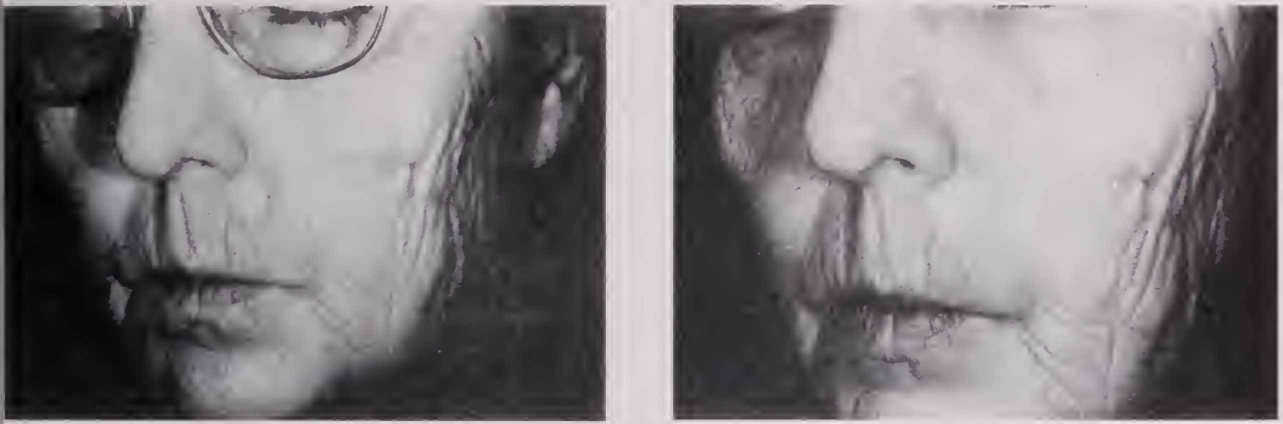


Fig. 8 *(Left)* Ring of brown pigment three months posttreatment. *(Right)* Disappearance of pigment one year posttreatment.

is encountered in about 5% of our patients treated with cryosurgery.

5. Hyperpigmentation around a treatment site (Fig. 8). Often the cryosurgical treatment of a lesion results in a peripheral ring of brown pigment. Occasionally, this may be quite prominent, but the pigment fades after a few months. This pigment represents only a graded response of the tissue to freezing resulting in increased melanin formation and deposition at the edge of the treatment field.

6. Depigmentation of the treatment site (Fig. 9). Whenever tissue is frozen to –30 C for two cycles, depigmentation may be expected. This is more prominent in the darker skin because of contrast. Some depigmentation will persist, but more satisfactory blending of skin color will occur in time so that the long term appearance improves, which is in contrast to the postradiation result.

CONCLUSIONS

Cryosurgery of skin cancer is not to be adopted to the exclusion of other established forms of treatment. It has its advantages as well as disadvantages. In proper perspective, it is a valuable addition to the classical methods of electrosurgery, excisional surgery, chemosurgery and radiation.

We repeat that the therapist who can utilize

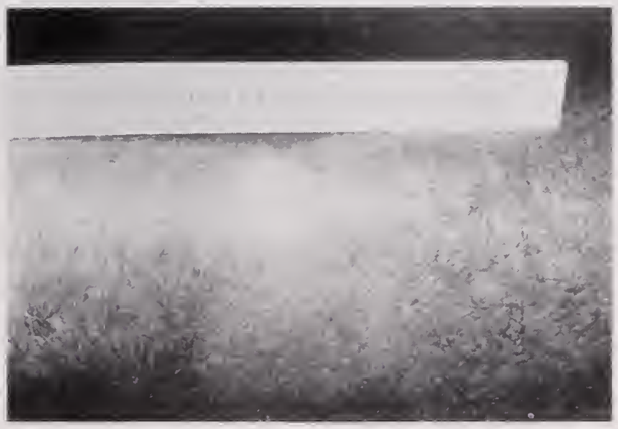


Fig. 9 Depigmentation, atrophy and loss of hair on forearm two years posttreatment. This is a poor result of cryosurgical treatment of a squamous carcinoma. A more acceptable result could have been achieved with a different method.

each of these modalities can then individualize treatment of each lesion according to its size, type, location and the age of the patient. In this way, we can be of the greatest overall service in the treatment of skin cancer.

Properly executed cryosurgery can achieve a cure rate of skin cancer as high as that of any other method.

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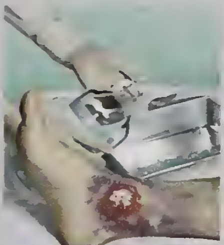
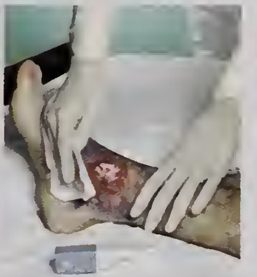
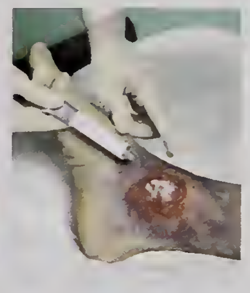


CLEANSE WOUND
Thoroughly cleanse and irrigate wound area with sodium chloride or water solutions. Wound MUST be cleansed of antiseptics or heavy-metal antibacterials.



THOROUGHLY MOISTEN
Thoroughly moisten wound area either through tubbing, showering, or wet soaks (e.g., sodium chloride or water solutions).



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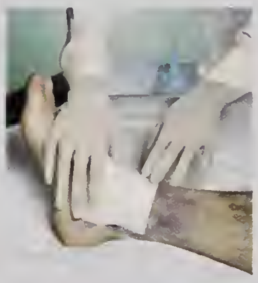
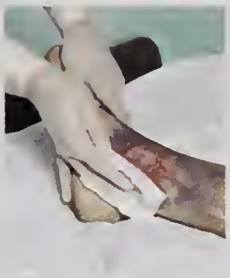


APPLY MOIST DRESSING
Apply loose moist dressings (most important with dry leathery eschar).



CHANGE DRESSINGS
When changing dressing, gently wipe away the dissolved material. Repeat the procedure, including application of TRAVASE Ointment, 3 to 4 times per day for best results.

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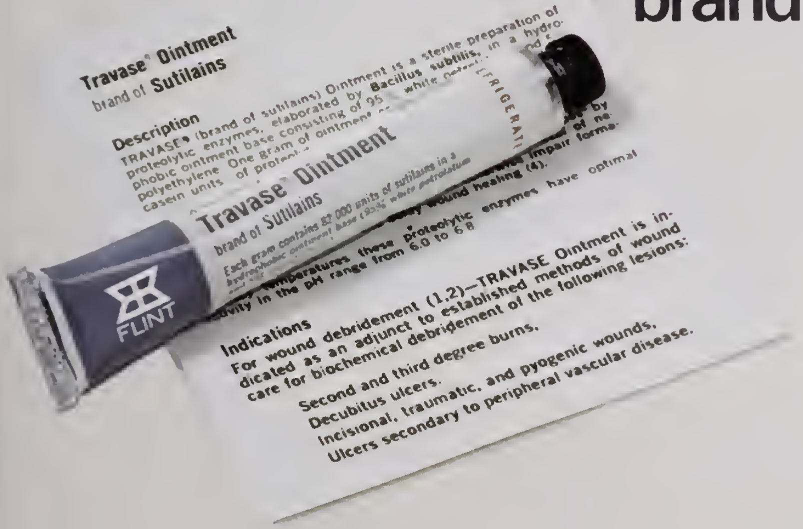

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FLINT
RIGERAT

Travase® Ointment
brand of **Sutilains**

Description
TRAVASE® (brand of sutilains) Ointment is a sterile preparation of proteolytic enzymes, elaborated by Bacillus subtilis, in a hydro-
phobic ointment base consisting of 95
polyethylene. One gram of ointment
casein units of protei

impair forma-
wound healing (4).
these proteolytic enzymes have optimal
temperatures
tivity in the pH range from 6.0 to 6.8

Indications
For wound debridement (1,2)—TRAVASE Ointment is indicated as an adjunct to established methods of wound care for biochemical debridement of the following lesions:

Second and third degree burns.
Decubitus ulcers.
Incisional, traumatic, and pyogenic wounds.
Ulcers secondary to peripheral vascular disease.

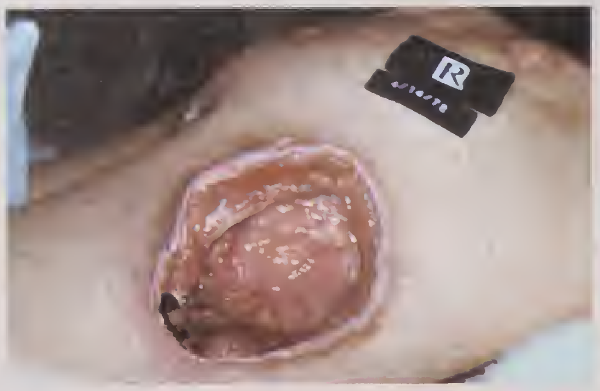
FLINT LABORATORIES
DIVISION OF TRAVENOL LABORATORIES, INC
Deerfield, Illinois 60015

Please see next page for prescribing information.

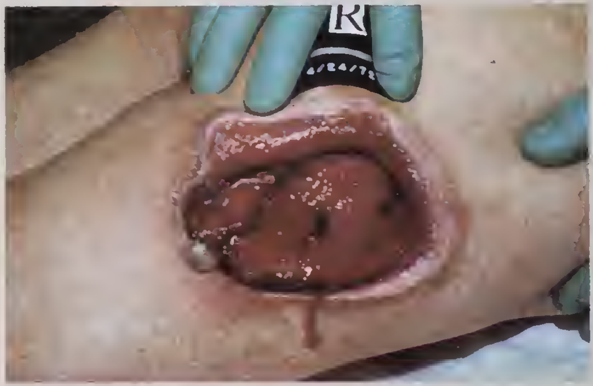
Travase® Ointment brand of Sutilains

ulcers

TERRY V. CARLE, M.D., CLINICAL INSTRUCTOR, DEPT. OF PHYS. MED. & REHAB.,
CRAIG REHABILITATION HOSPITAL, UNIVERSITY OF COLORADO



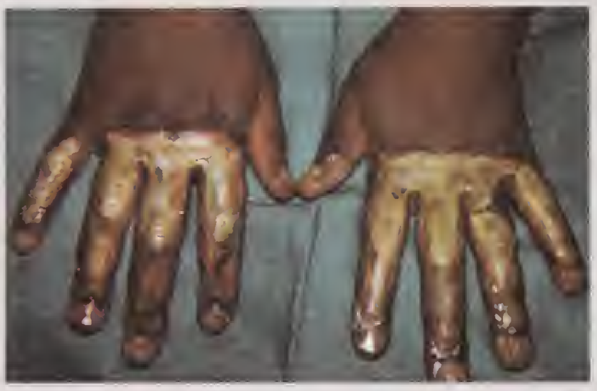
Before treatment, necrotic matter coated the inner surfaces of this decubitus ulcer.



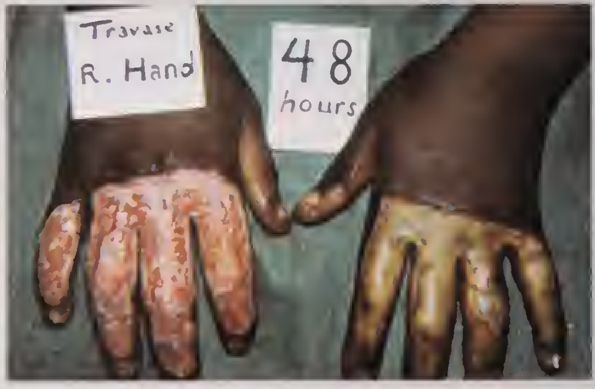
After nine days of TRAVASE therapy, debridement is nearly complete and granulation evident.

burns

DALE B. DUBIN, M.D., DIPLOMATE,
AMERICAN BOARD OF PLASTIC SURGERY, TAMPA, FLORIDA



Before treatment . . .



48 hours following treatment with TRAVASE Ointment on right hand; left hand is control.

Travase® Ointment

(brand of Sutilains)

Indications: For wound debridement, TRAVASE Ointment is indicated as an adjunct to established methods of wound care for biochemical debridement of the following lesions:

- Second and third degree burns,
- Decubitus ulcers,
- Incisional, traumatic, and pyogenic wounds,
- Ulcers secondary to peripheral vascular disease.

Contraindications: Application of TRAVASE Ointment is contraindicated in the following conditions.

- Wounds communicating with major body cavities,
- Wounds containing exposed major nerves or nervous tissue,
- Fungating neoplastic ulcers,
- Wounds in women of child-bearing potential—because of lack of laboratory evidence of effects of TRAVASE upon the developing fetus.

Warning: Do not permit TRAVASE Ointment to come into contact with the eyes. If contact is made, immediately rinse with copious amounts of water, preferably sterile.

Precautions: A moist environment is essential to optimal activity of the enzyme. Enzyme activity may also be impaired by certain agents (see package insert). Although there have been no reports of systemic allergic reaction in humans, studies have shown that there may be an antibody response in humans to absorbed enzyme material.

Adverse Reactions: Consist of mild, transient pain, paresthesias, bleeding and transient dermatitis. Pain usually can be controlled by administration of mild analgesics. Side effects severe enough to warrant discontinuation of therapy occasionally have occurred.

If bleeding or dermatitis occurs as a result of the application of TRAVASE Ointment, therapy should be discontinued. No systemic toxicity has been observed as a result of the topical application of TRAVASE Ointment.

DOSAGE AND ADMINISTRATION: STRICT ADHERENCE TO THE FOLLOWING IS REQUIRED FOR EFFECTIVE RESULTS OF TREATMENT:

1. Thoroughly cleanse and irrigate wound area with sodium chloride or water solutions. Wound MUST be cleansed of antiseptics or heavy-metal antibacterials which may denature enzyme or alter substrate characteristics (e.g., hexachlorophene, silver nitrate, benzalkonium chloride, nitrofurazone, etc.).
2. Thoroughly moisten wound area either through tubbing, showering, or wet soaks (e.g. sodium chloride or water solutions).
3. Apply TRAVASE Ointment in a thin layer assuring intimate contact with necrotic tissue and complete wound coverage extending ¼ to ½ inch beyond the area to be debrided.
4. Apply loose wet dressings.
5. Repeat entire procedure 3 to 4 times per day for best results.

FLINT LABORATORIES
DIVISION OF TRAVENOL LABORATORIES, INC.
Deerfield, Illinois 60015

J. Bernard Finucane

We are pleased
to announce
that

J. Bernard Finucane
Vice-President—Sales and Marketing

was elected

PRESIDENT

of the

American Surgical Trade Association

For the Year 1974-1975 at the Annual
Meeting Held in Washington, D.C. on October 6-10, 1974

MUNNS
MEDICAL
SUPPLY

MUNNS MEDICAL SUPPLY COMPANY, Inc.

Must vasodilators and therapy for other diseases come into conflict?

not if the vasodilator is

VASODILAN®

(ISOXSUPRINE HCl)

the compatible vasodilator... no treatment conflicts reported

The cerebral or peripheral vascular disease patient often has coexisting disease[1] which calls for another drug along with his vasodilator. It may be a hypoglycemic, miotic, antihypertensive, diuretic, anticoagulant, corticosteroid, or coronary vasodilator.

Vasodilan is not incompatible with any of these drugs—no treatment conflict has been reported. And, unlike other vasodilators, Vasodilan has not been reported to affect carbohydrate metabolism, liver function, or intraocular pressure—or to complicate treatment of diabetes, hypertension, peptic ulcer, glaucoma, or liver disease.

In fact, there are no known contraindications to the use of Vasodilan in recommended oral doses, other than that it should not be given in the presence of frank arterial bleeding or immediately postpartum.

Indications: Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows:

Possibly Effective:

1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.
3. Threatened abortion.

Final classification of the less-than-effective indications requires further investigation.

Composition: Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg.

Dosage and Administration: 10 to 20 mg. three or four times daily.

Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

Adverse Reactions: On rare occasions, oral administration of the drug has been associated in time with the occurrence of severe rash. When rash appears, the drug should be discontinued. Occasional overdosage effects such as transient palpitation or dizziness are usually controlled by reducing the dose.

Supplied: Tablets, 10 mg.—bottles of 100, 1000, 5000 and Unit Dose; 20 mg.—bottles of 100, 500 and Unit Dose.

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Mead Johnson LABORATORIES

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[1] Gertler, M. M., et al.: Geriatrics *25*:134-148 (May) 1970.

President's Message

Let there be no mistake. We are having an epidemic of gonorrhea. Unless something has happened since I worked in a VD Clinic, the incidence of syphilis will follow in a ratio of one to ten.

In 1950, I was treating about two cases of GC a year. I now see about two a week, as do the other two urologists in my office.

There are a number of reasons for this. First is the development and widespread use of the birth control pill. I think it would be correct to say that except for those who want to become pregnant or those who are otherwise sterile, every sexually active female in the United States is on the pill. As a result, the condom is no longer used for contraception. Its incidental but valuable protection against venereal disease has been lost.

Second is the absence of fear of contracting a venereal disease. The idea, sometimes wrong, that gonorrhea and syphillis are easily cured and without consequence is widespread.

The third reason is almost total and universal ignorance. It is strange to treat a 25-year-old man with classical gonorrhea who has no idea of what is wrong or how he became infected. Very few of the patients I see know that precautions can be taken to prevent an infection.

James C. Cope, M.D.

Fourth: Nonexistence of a comprehensive, far-reaching educational program.

Fifth: Inadequate facilities for VD prophylaxis. Even the individual pro-kit is no longer available in the drugstore.

As in many other areas of preventable disease, there is not much the physician can do other than treat the infection after it occurs. Here is a real opportunity for the educators, sociologists, legislators and public health officials to provide Health Care. The physicians will continue to provide medical care as needed and to help with the educational program. There is one thing, however, that every physician should do (he is, in fact, breaking the law by not doing it) and that is to accurately report all cases. I'm aware that many physicians feel that reporting a case of gonorrhea is fruitless since no direct follow-up is made. While this is true, it also is true that the health authorities need an accurate statistical base from which to plan an attack. The physician must supply this base by accurate reporting. I have talked with Dr. Herbert Domke, Director of the Missouri Division of Health, about this. He is most disturbed that he does not have reliable statistics.

Obey the law—report your cases.

Physicians.
Isn't it time your
career had a check-up?

Of course, we don't mean to imply that your career isn't a healthy one. We just want to draw your attention to the personal and career opportunities and benefits the Air Force has to offer you. You'll discover that the Air Force is a challenging and rewarding way of life. Our hospitals and clinics are outstanding. Plus, we'll pay relocation expenses for your family and household goods. If you're interested in our medical plan, find out all the facts. Sometimes, even a healthy career could use a checkup.

AIR FORCE MEDICAL PLACEMENT OFFICE
1734 East 63rd St., Suite 110
Kansas City, Mo. 64110
816-926-5424

Woman's Auxiliary

50th Anniversary

Each year when Father Time retires in favor of the Infant New Year, new resolutions for the coming year take priority. What can this Baby New Year expect? Please consider these suggestions:

Resolution: The Woman's Auxiliary to the Missouri State Medical Association resolves to increase its membership by at least 100 members in 1975. This resolution should be easy to attain if the following reasons for joining are considered:

1. The Woman's Auxiliary is the only organization in which the doctor's wife can join forces with all other Missouri doctors' wives to assist the medical profession in its program for the advancement of medicine and the betterment of public health.
2. Auxiliary membership declares to the public that the doctor's wife is proud to be associated with her husband's professional group and approves of its goals.
3. Auxiliary membership demonstrates to the public that the doctor's wife is eager to serve her community.

Mrs. George J. Lytton
President

Resolution: Members of the Auxiliary resolve to increase their efforts on behalf of good legislation in the coming year. This is an area in which the doctor's wife can really help her busy husband. Each member should resolve to be informed of current legislation and to alert members of Congress to the will of the people. Support of AMPAC and MPAC also is a must for every Auxiliary member.

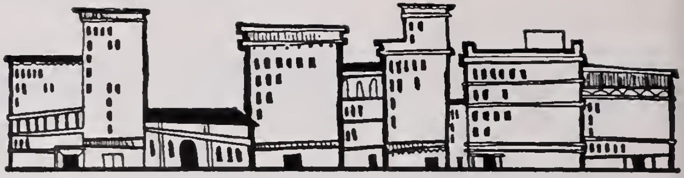
Resolution: All programs of the Auxiliary will be supported by each member. This support may take various directions. It involves work in communities. It involves attendance and participation in all meetings. It involves members in encouraging others to attend meetings. The American Medical Association-Education and Research Foundation (AMA-ERF) and Missouri State Medical Foundation (MSMF) are also important programs requiring constant efforts.

Resolution: All lines of communications will be kept open and all communications will be two-way.

The infant New Year will smile happily if all these resolutions are instituted and followed. What a great year 1975 can be!

HAPPY 1975!

From the Medical Schools



UNIVERSITY OF MISSOURI-COLUMBIA

Dr. Donald Silver, currently a professor at Duke University Medical Center, has been named chairman of the Department of Surgery at the UMMC School of Medicine and Medical Center. He will move to Columbia to assume his new duties about February 1, according to Provost for Health Affairs Joseph M. White.

Dr. Silver

The new chairman also will have the title, W. Alton Jones Distinguished Professor of Surgery. The academic chair was formerly occupied by Dr. Marion S. DeWeese who served as chairman of the Department of Surgery from 1964 until his resignation Sept. 1, 1974. Dr. DeWeese has entered private practice at his former home in Ann Arbor, Mich. In the interim period, Dr. Hugh E. Stephenson, Jr. is acting departmental chairman.

Dr. Silver is certified by the American Board of Surgery and by the American Board of Thoracic and Cardiovascular Surgery. His special research interest is in vascular surgery and his clinical interest is in thrombolic disorders, the type of medical problems that have plagued former President Nixon.

Dedication ceremonies for the Howard A. Rusk Rehabilitation Center were held on November 30 in McHaney Hall at the University. The center is part of a $1 million addition to McHaney Hall funded by the Missouri Division of Vocational Rehabilitation, the Seeing Eye Foundation and private gifts. The objective of the center's program is to help disabled persons live the best life they can, said Dr. Howard A. Rusk, a 1923 graduate of the University's School of Medicine. The center is named in his honor and will treat persons who have been paralyzed, lost a limb or suffered a stroke.

UNIVERSITY OF MISSOURI-KANSAS CITY

Richard J. Dickerson was presented with the "Outstanding Teacher Award" by the student body of the UMKC School of Medicine. Mr. Dickerson is a graduate student who has been teaching anatomy to the UMKC medical students for about two years.

Robert L. Hawley, M.D., joined the medical school faculty on Dec. 1, 1974. Dr. Hawley has spent most of his professional life as a pathologist. Two years ago, he began a clinical cardiology fellowship which he finished shortly before joining the UMKC faculty. Dr. Hawley will be fourth Docent on the Blue Docent Unit in the School of Medicine.

Construction is progressing on the Truman Medical Center, with the third floor concrete now being poured. The anticipated completion date on this hospital will be August 1976. Truman Medical Center was financed through a Jackson County bond issue of $14,000,000, with $16,000,000 of federal matching grant and loan funds. The building will be connected with the UMKC School of Medicine on the north side and will replace Kansas City General Hospital and Medical Center, which presently houses Docent Units.

WASHINGTON UNIVERSITY

A $1 million grant has been awarded to a Washington University School of Medicine geneticist for research on enzyme replacement therapy.

William S. Sly, M.D., associate professor of medicine and of pediatrics, and director of the Division of Genetics, is principal investigator of the four-year study funded by the National Institutes of Health.

"The research team will be testing the possibility of enzyme replacement as a means of treatment for storage diseases," Dr. Sly said. The initial studies are concentrating on the mucopolysaccharide storage disease caused by a deficiency in a beta-glucuronidase.

Dr. Sly, who joined the Washington University faculty in 1964, received the M.D. degree in 1957 from St. Louis University School of Medicine.

Other investigators on this research are *Philip D. Stahl,* Ph.D., assistant professor of physiology and biophysics; *Elliott C. Bell, Jr.,* M.D., assistant professor of medicine and of pathology; *David M. Geller,* Ph.D., associate professor of pharmacology; and *Frederick E. Brot,* Ph.D., research instructor in pediatrics.

ST. LOUIS UNIVERSITY

A delegation of five distinguished Soviet scientists visited the St. Louis University Medical Center on November 4 as part of a U.S.-U.S.S.R. continuing cooperative project on Management of Ischemic Heart Disease.

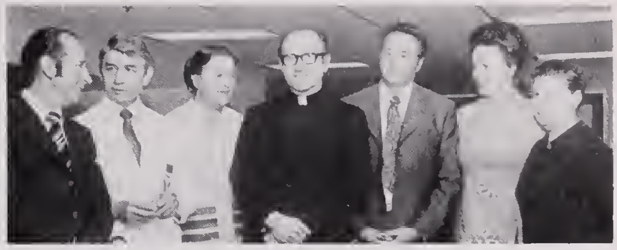
Hosting the St. Louis University Medical Center visit was *Dr. Vallee L. Willman,* a member of the four-man U. S. ischemic heart expert team which spent two weeks in Russia in September of 1973 and again in June of 1974. He is professor and chairman of the Department of Surgery at the St. Louis University School of Medicine.

The Russian delegation had not been scheduled by our government authorities to visit St. Louis during their trip to the United States but requested that a visit be arranged for them at the St. Louis University Medical Center.

It was the second visit to this area for the U.S.S.R. Project Chairman, *Prof. Igor K. Shkhvatsabaya,* Doctor of Medical Sciences, Professor, Director of Myasnikov Research Institute of Cardiology, who visited the St. Louis University Medical Center in 1973. The four other scientists visited St. Louis University for the first time.

Soviet and American heart experts have engaged in a cooperative research attack against the greatest cause of death in both countries—coronary heart disease. Experts of both countries, including Dr. Willman of St. Louis, have been working since 1972 in a project which aims, over a period of years, to evaluate and compare chronic angina and heart attack disability treatment methods that have been developed in each country separately until now.

An immediate goal of the Project members visiting St. Louis is to continue establishing standard definitions, criteria and methods as a common ground for both countries. It is envisioned that detailed plans of action incorporating these standards and major points of agreement will be ready for implementation by the first of January, 1975. It is anticipated that the exchange project will continue for several years.



Dr. Willman *(second left)* meets with Russian delegates during October visit to the St. Louis University Medical Center. U.S.S.R. Project chairman, Professor Igor K. Shkhvatsabaya *(left)* accompanied the Soviet scientists to St. Louis. Rev. Daniel C. O'Connell, S.J., President of St. Louis University *(fourth left),* was present at a reception honoring their arrival at the Medical Center.

★
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County Society News

FIRST DISTRICT

COUNCILOR
JOHN N. MARTIN, M.D., ST. JOSEPH

BUCHANAN COUNTY MEDICAL SOCIETY

The annual dinner and installation of officers of the Buchanan County Medical Society were held on December 4 at the St. Joseph Country Club. Ninety-two physicians and their wives attended the event.

Dr. Randal W. Weed, retiring President, presided and served as installing officer. Dr. William O'Connor was installed as President for 1975. Other officers installed are Dr. G. Tyson Carpenter, President-Elect; Dr. Richard O. Craig, Vice-President; Dr. Carl K. Ness, Secretary; and Dr. Robert W. Kieber, Treasurer. who will serve his 22nd consecutive year in this office.

Dr. Joseph R. Prokop was named to the Board of Censors. MSMA Delegates are Dr. Donald J. Stallard and Dr. Ernest E. Wadlow with Drs. R. Philip Acuff, Gerald E. Fox and Gordon S. Paulson as Alternate Delegates.

Dr. F. Gregg Thompson III will serve as a Trustee until 1980. Dr. Robert R. Stuber will be on the Committee on Public Policy and Dr. Weed will serve on the Executive Secretary Committee.

Following the program, the Kicks Band played for dancing. A special program was arranged by Mrs. Lawrence H. Pifer, Buchanan County Auxiliary President, Mrs. Edward M. Stevens and Dr. John N. Martin. Meeting arrangements were made by the Society Program Committee with Dr. Edward M. Beheler, Chairman, and Dr. Edward H. Andres and Dr. Robert R. Stuber. Mrs. Beheler was in charge of decorations and the Notification Committee.

CARL K. NESS, M.D., *Secretary*

New Members

Victor R. Adebimpe, M.D., 5400 Arsenal, St. Louis, has become a member of St. Louis County Medical Society. Dr. Adebimpe is a native of Nigeria, received his preliminary education at King's College and his M.D. degree at the University of Ibadan in 1971. He specializes in psychiatry.

Michael Alul, M.D., 1650 Boonslick, St. Charles, has become a member of St. Charles-Lincoln County Medical Society. Dr. Alul is a native of Nablus-Jordan, received his preliminary education at the University of Beirut and his M.D. degree at Alexandria School of Medicine in 1969. He specializes in pediatrics.

Carol R. Archer, M.D., 510 S. Kingshighway, St. Louis, has become a member of St. Louis Medical Society. Dr. Archer is a native of California, received her preliminary education at the University of California and her M.D. degree at McGill University in 1956. She specializes in radiology.

Tyrone D. Artz, M.D., 6724 Troost, Kansas City, has become a member of Jackson County Medical Society. Dr. Artz is a native of Kingsley, Ia., received his preliminary education at Iowa State University and his M.D. degree at the University of Iowa in 1967. He specializes in orthopedic surgery.

Richard Baldwin, Jr., M.D., 50 Overhill, St. Louis, has become a member of St. Louis Medical Society. Dr. Baldwin is a native of St. Louis, received his preliminary education at Princeton University and his M.D. degree at the University of Cincinnati in 1968. He specializes in orthopedic surgery.

Richard L. Bartley, M.D., Taylor Health Center, Southwest Missouri State University, Springfield, has become a member of Greene County Medical Society. Dr. Bartley is a native of Lincoln, Neb., received his preliminary education at Nebraska Wesleyan University and his M.D. degree at the University of Nebraska in 1947. He is in family practice.

Vinod S. Bhatara, M.D., 1221 S. Grand, St. Louis, has become a member of St. Louis Medical Society. Dr. Bhatara is a native of India, received his preliminary education at Punjab University and his M.D. degree at All-India Institute of Medical Sciences in 1969. He specializes in psychiatry.

John D. Blair, M.D., 1465 S. Grand, St. Louis, has become a member of St. Louis Medical Society. Dr. Blair is a native of Cuba, received his preliminary education at Dolores College and his M.D. degree at the University of Havana in 1956. He specializes in pathology.

(Continued on next page)

Before prescribing, see complete prescribing information in SK&F literature or *PDR*. The following is a brief summary.

Indications: Edema associated with congestive heart failure, cirrhosis of the liver, the nephrotic syndrome; steroid-induced and idiopathic edema; edema resistant to other diuretic therapy. Also, mild to moderate hypertension.

Contraindications: Pre-existing elevated serum potassium. Hypersensitivity to either component. Continued use in progressive renal or hepatic dysfunction or developing hyperkalemia.

Warnings: **Do not use dietary potassium supplements or potassium salts unless hypokalemia develops or dietary potassium intake is markedly impaired.** Enteric-coated potassium salts may cause small bowel stenosis with or without ulceration. Hyperkalemia (>5.4 mEq/L) has been reported in 4% of patients under 60 years, in 12% of patients over 60 years, and in less than 8% of patients overall. Rarely, cases have been associated with cardiac irregularities. **Accordingly, check serum potassium during therapy, particularly in patients with suspected or confirmed renal insufficiency (e.g., elderly or diabetics). If hyperkalemia develops, substitute a thiazide alone. If spironolactone is used concomitantly with 'Dyazide', check serum potassium frequently—both can cause potassium retention and sometimes hyperkalemia.** Two deaths have been reported in patients on such combined therapy (in one, recommended dosage was exceeded; in the other, serum electrolytes were not properly monitored). Observe patients on 'Dyazide' regularly for possible blood dyscrasias, liver damage or other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving Dyrenium (triamterene, SK&F). Rarely, leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with the thiazides. Watch for signs of impending coma in acutely ill cirrhotics. Thiazides are reported to cross the placental barrier and appear in breast milk. This may result in fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly other adverse reactions that have occurred in the adult. When used during pregnancy or in women who might bear children, weigh potential benefits against possible hazards to fetus.

Precautions: Do periodic serum electrolyte and BUN determinations. Do periodic hematologic studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in postsympathectomy patients. The following may occur: hyperuricemia and gout, reversible nitrogen retention, decreasing alkali reserve with possible metabolic acidosis, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), digitalis intoxication (in hypokalemia). Use cautiously in surgical patients. Concomitant use with antihypertensive agents may result in an additive hypotensive effect.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis; rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting (may indicate electrolyte imbalance), diarrhea, constipation, other gastrointestinal disturbances. Rarely, necrotizing vasculitis, paresthesias, icterus, pancreatitis, and xanthopsia have occurred with thiazides alone.

Supplied: Bottles of 100 capsules; in Single Unit Packages of 100 (intended for institutional use only).

SK&F CO.
Carolina, P.R. 00630
Subsidiary of
SmithKline Corporation

KEEP THE HYPERTENSIVE PATIENT ON THERAPY
KEEP THERAPY SIMPLE WITH
DYAZIDE®
Trademark

Each capsule contains 50 mg. of Dyrenium® (brand of triamterene) and 25 mg. of hydrochlorothiazide.

Just 'Dyazide' once daily or twice daily
No inconvenient potassium supplements
Nor special K+ rich diets needed as a rule

20
40
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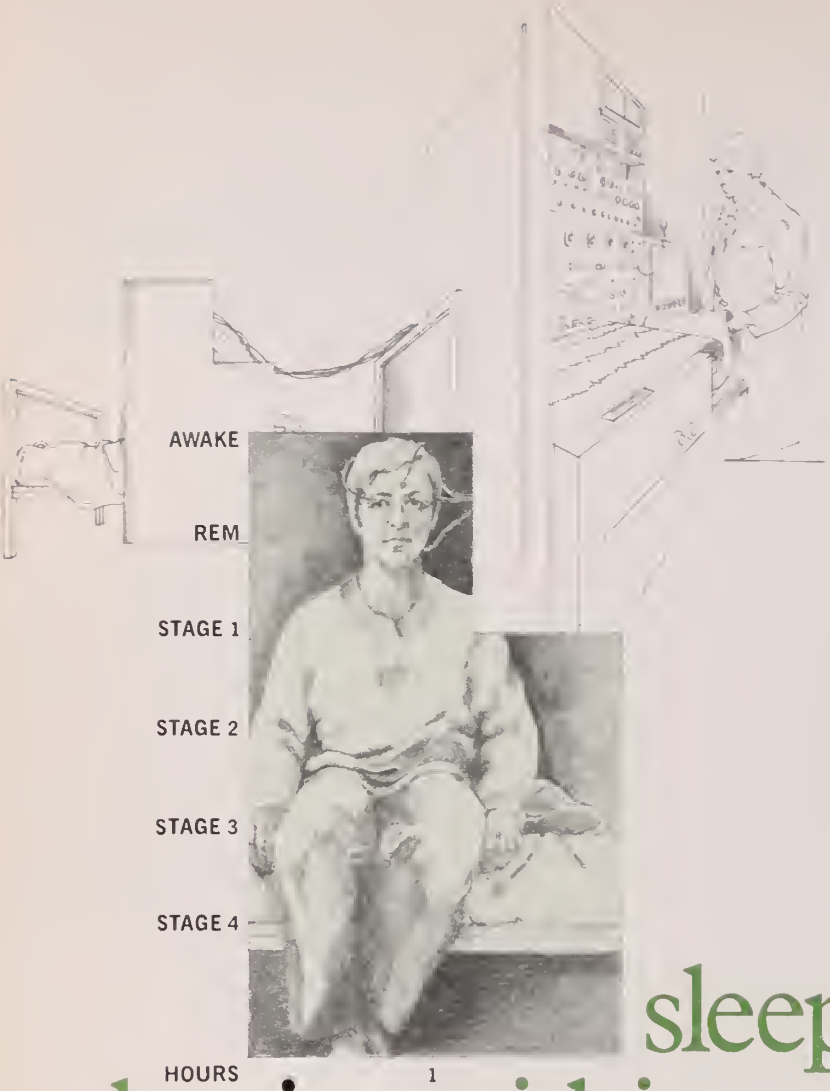
300

Two prime reasons patients drop out of hypertensive therapy are (1) the patient failed to understand directions, and (2) the regimen was overly complicated. Dosage is simple with 'Dyazide', easily understood, once or twice daily, depending on response. There's no need to complicate the regimen with potassium supplements or unwieldy potassium-rich diets.

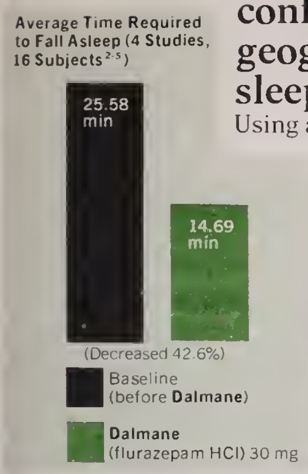
TO KEEP BLOOD PRESSURE DOWN AND KEEP POTASSIUM LEVELS UP



sleep
begins within
17 minutes, on average...
an initial benefit of

Dalmane®
(flurazepam HCl) **proved by a**
22-night clinical study of insomnia patients
in the sleep research laboratory and at home[1]

Three insomnia patients selected for difficulty falling asleep were administered Dalmane (flurazepam HCl) 30 mg for 14 consecutive nights. Placebo was given for four nights prior to and four nights after Dalmane. Physiologic tracings on Dalmane nights 1-3 showed sleep induction time averaged 13.90 minutes; on Dalmane nights 12-14, 18.80 minutes. Combined average for the 6 monitored drug nights was 16.35 minutes.[1]



confirmed by clinical studies in four geographically separated sleep research laboratories[2-5]

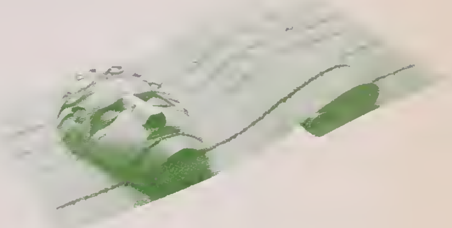
Using a 14-night protocol involving eight insomniac and eight normal subjects, four studies confirmed the sleep-inducing effectiveness of Dalmane (flurazepam HCl) and the reproducibility of this response. On average, one 30-mg capsule induced sleep within 17 minutes. In all these studies, Dalmane induced sleep rapidly, reduced nighttime awakenings, and provided 7 to 8 hours of sleep without repeating dosage.[2-5]

Dalmane (flurazepam HCl) induces and maintains sleep, with relative safety

Dalmane is generally well tolerated; morning "hang-over" has been relatively infrequent. While dizziness, drowsiness, lightheadedness and the like have been noted most often, particularly in the elderly and debilitated, physicians should be aware of the possibility of more serious reactions, as noted below.

Before prescribing Dalmane (flurazepam HCl), please consult Complete Product Information, a summary of which follows:

Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; and in acute or chronic medical situations requiring restful sleep. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended.
Contraindications: Known hypersensitivity to flurazepam HCl.
Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. Caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Use in women who are or may become pregnant only when potential benefits have been weighed against possible hazards. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage.
Precautions: In elderly and debilitated, initial dosage should be limited to 15 mg to preclude oversedation, dizziness and/or ataxia. If combined with other drugs having hypnotic or CNS-depressant effects, consider potential additive effects. Employ usual precautions in patients who are severely depressed, or with latent depression or suicidal tendencies. Periodic blood counts and liver and kidney function tests are advised during repeated therapy. Observe usual precautions in presence of impaired renal or hepatic function.
Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported were headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins and alkaline phosphatase. Paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity, have also been reported in rare instances.
Dosage: Individualize for maximum beneficial effect. *Adults:* 30 mg usual dosage; 15 mg may suffice in some patients. *Elderly or debilitated patients:* 15 mg initially until response is determined.
Supplied: Capsules containing 15 mg or 30 mg flurazepam HCl.



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One 15-mg capsule *h.s.* — initial dosage for elderly or debilitated patients.

- **induces sleep within 17 minutes, on average**
- **reduces nighttime awakenings**
- **sustains sleep 7 to 8 hours, on average, without repeating dosage**

REFERENCES: 1. Kales A, *et al*: *Arch Gen Psychiatry* 23:226-232, Sep 1970
2. Karacan I, Williams RL, Smith JR: The sleep laboratory in the investigation of sleep and sleep disturbances. Scientific exhibit at the 124th annual meeting of the American Psychiatric Association, Washington DC, May 3-7, 1971
3. Frost JD Jr: Data on file, Medical Department, Hoffmann-La Roche Inc, Nutley NJ
4. Vogel GW: Data on file, Medical Department, Hoffmann-La Roche Inc, Nutley NJ
5. Dement WC: Data on file, Medical Department, Hoffmann-La Roche Inc, Nutley NJ

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When diarrhea has his number...

Lomotil puts him back in the game.

Physicians and patients both want prompt control of the symptoms of diarrhea. A rapid, uncontrolled loss of fluids and electrolytes can cause a medical crisis, particularly in children, and in patients who are seriously ill, or in people who are badly undernourished.

Lomotil usually stops diarrhea promptly. This rapid action halts the emergency aspect of diarrhea and is comforting and reassuring to the patient. Electrolyte and fluid losses can be corrected while the specific cause of the diarrhea is being determined. If an infective agent is the cause, appropriate antibiotic therapy should be given along with Lomotil.

Lomotil has few side effects, and those that do occur are generally mild.

Lomotil®
TABLETS/LIQUID

Each tablet and each 5 ml. of liquid contain:
diphenoxylate hydrochloride ...... 2.5 mg.
(Warning: May be habit forming)
atropine sulfate .... 0.025 mg.

Usually stops diarrhea promptly.

IMPORTANT INFORMATION: This is a Schedule V substance by Federal law; diphenoxylate HCl is chemically related to meperidine. In case of overdosage or individual hypersensitivity, reactions similar to those after meperidine or morphine overdosage may occur; treatment is similar to that for meperidine or morphine intoxication (prolonged and careful monitoring). Respiratory depression may recur in spite of an initial response to Nalline® (nalorphine HCl) or may be evidenced as late as 30 hours after ingestion. LOMOTIL IS NOT AN INNOCUOUS DRUG AND DOSAGE RECOMMENDATIONS SHOULD BE STRICTLY ADHERED TO, ESPECIALLY IN CHILDREN. THIS MEDICATION SHOULD BE KEPT OUT OF REACH OF CHILDREN.

Indications: Lomotil is effective as adjunctive therapy in the management of diarrhea.

Contraindications: In children less than 2 years, due to the decreased safety margin in younger age groups, and in patients who are jaundiced or hypersensitive to diphenoxylate HCl or atropine.

Warnings: Use with caution in young children, because of variable response, and with extreme caution in patients with cirrhosis and other advanced hepatic disease or abnormal liver function tests, because of possible hepatic coma. Diphenoxylate HCl may potentiate the action of barbiturates, tranquilizers and alcohol. In theory, the concurrent use with monoamine oxidase inhibitors could precipitate hypertensive crisis.

Usage in pregnancy: Weigh the potential benefits against possible risks before using during pregnancy, lactation or in women of childbearing age. Diphenoxylate HCl and atropine are secreted in the breast milk of nursing mothers.

Precautions: Addiction (dependency) to diphenoxylate HCl is theoretically possible at high dosage. Do not exceed recommended dosages. Administer with caution to patients receiving addicting drugs or known to be addiction prone or having a history of drug abuse. The subtherapeutic amount of atropine is added to discourage deliberate overdosage; strictly observe contraindications, warnings and precautions for atropine; use with caution in children since signs of atropinism may occur even with the recommended dosage.

Adverse reactions: Atropine effects include dryness of skin and mucous membranes, flushing and urinary retention. Other side effects with Lomotil include nausea, sedation, vomiting, swelling of the gums, abdominal discomfort, respiratory depression, numbness of the extremities, headache, dizziness, depression, malaise, drowsiness, coma, lethargy, anorexia, restlessness, euphoria, pruritus, angioneurotic edema, giant urticaria and paralytic ileus.

Dosage and administration: ***Lomotil is contraindicated in children less than 2 years old.*** Use only Lomotil liquid for children 2 to 12 years old. For ages 2 to 5 years, 4 ml. (2 mg.) t.i.d.; 5 to 8 years, 4 ml. (2 mg.) q.i.d.; 8 to 12 years, 4 ml. (2 mg.) 5 times daily; adults, two tablets (5 mg.) t.i.d. to two tablets (5 mg.) q.i.d. or two regular teaspoonfuls (10 ml., 5 mg.) q.i.d. Maintenance dosage may be as low as one fourth of the initial dosage. Make downward dosage adjustment as soon as initial symptoms are controlled.

Overdosage: Keep the medication out of the reach of children since accidental overdosage may cause severe, even fatal, respiratory depression. Signs of overdosage include flushing, lethargy or coma, hypotonic reflexes, nystagmus, pinpoint pupils, tachycardia and respiratory depression which may occur 12 to 30 hours after overdose. Evacuate stomach by lavage, establish a patent airway and, when necessary, assist respiration mechanically. Use a narcotic antagonist in severe respiratory depression. Observation should extend over at least 48 hours.

Dosage forms: Tablets, 2.5 mg. of diphenoxylate HCl with 0.025 mg. of atropine sulfate. *Liquid,* 2.5 mg. of diphenoxylate HCl and 0.025 mg. of atropine sulfate per 5 ml. A plastic dropper calibrated in increments of ½ ml. (total capacity, 2 ml.) accompanies each 2-oz. bottle of Lomotil liquid.

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James Blythe, M.D., 615 S. New Ballas, St. Louis, has become a member of St. Louis Medical Society. Dr. Blythe is a native of Illinois, received his preliminary education at Greenville College and his M.D. degree at St. Louis University in 1966. He specializes in gynecologic oncology.

Corey A. Bohling, M.D., 615 S. New Ballas, St. Louis, has become a member of St. Louis Medical Society. Dr. Bohling is a native of Indiana, received his preliminary education at the University of Washington and his M.D. degree at the University of Missouri in 1968. He is a resident in general surgery.

Wilson Bourjolly, M.D., 2601 N. Whittier, St. Louis, has become a member of St. Louis Medical Society. Dr. Bourjolly is a native of Haiti, received his preliminary education at the Institution St. Louis of Gonzaque and his M.D. degree at the Faculty of Medicine in 1966. He specializes in ophthalmology.

Cesar A. Bravo, M.D., 2316 E. Meyer Blvd., Kansas City, has become a member of Jackson County Medical Society. Dr. Bravo is a native of Peru, received his preliminary education at the University of Trujillo and his M.D. degree at the University of Trujillo in 1967. He specializes in internal medicine.

William J. Brian, M.D., 229 Professional Bldg., Springfield, has become a member of Greene County Medical Society. Dr. Brian is a native of El Dorado, Kan., received his preliminary education at Wichita State University and his M.D. degree at Kansas University in 1971. He specializes in anesthesiology.

John B. Buettner, M.D., 3106 Queeny Towers, St. Louis, has become a member of St. Louis Medical Society. Dr. Buettner is a native of St. Louis, received his preliminary education at Dartmouth College and his M.D. degree at Washington University in 1967. He specializes in general surgery.

Tasanaporn Bunthrarungroj, M.D., 825 Euclid, Kansas City, has become a member of Jackson County Medical Society. Dr. Bunthrarungroj is a native of Thailand, received her preliminary education at Chulalongkorn University and her M.D. degree at Mahidol University in 1966. She specializes in pediatrics.

Milton L. Cobb, M.D., Barnes Hospital Plaza, St. Louis, has become a member of St. Louis Medical Society. Dr. Cobb is a native of Texas, received his preliminary education at Baylor University and his M.D. degree at the University of Texas in 1968. He specializes in anesthesiology.

Edward Cohen, M.D., 4511 Forest Park, St. Louis, has become a member of St. Louis Medical Society. Dr. Cohen is a native of St. Louis, received his preliminary education at Washington University and his M.D. degree at the University of Missouri in 1969. He specializes in radiology.

John P. Connors, M.D., 4960 Audubon, St. Louis, has become a member of St. Louis Medical Society. Dr. Connors is a native of Massachusetts, received his preliminary education at Holy Cross College and his M.D. degree at Georgetown University in 1965. He specializes in general surgery.

James W. Debnam, Jr., M.D., 510 S. Kingshighway, St. Louis, has become a member of St. Louis Medical Society. Dr. Debnam is a native of Kentucky, received his preliminary education at the University of Louisville and his M.D. degree at the University of Louisville in 1962. He specializes in radiology.

Tony M. Deeths, M.D., 510 S. Kingshighway, St. Louis, has become a member of St. Louis Medical Society. Dr. Deeths is a native of Kansas, received his preliminary education at Johns Hopkins University and his M.D. degree at the Medical College of Wisconsin in 1970. He specializes in radiology.

Ravindra Desai, M.D., 2850 W. Clay, St. Charles, has become a member of St. Charles-Lincoln County Medical Society. Dr. Desai is a native of India, received his preliminary education at the Faculty of Science, India and his M.D. degree at M.S. University of Baroda in 1960. He specializes in otolaryngology.

George F. Duensing, M.D., 211 S. 3rd, Louisiana, has become a member of Pike County Medical Society. Dr. Duensing is a native of Chicago, Ill., received his preliminary education at the University of Missouri-Columbia and his M.D. degree at the University of Missouri in 1972. He is in general practice.

Robert H. Durie, M.D., 2929 Baltimore, Kansas City, has become a member of Jackson County Medical Society. Dr. Durie is a native of Raton, N. M., received his preliminary education at William Jewell College and his M.D. degree at Kansas University in 1961. He specializes in internal medicine.

John W. Durkin, Jr., M.D., 6150 Oakland, St. Louis, has become a member of St. Louis Medical Society. Dr. Durkin is a native of New York, received his preliminary education at the University of Vermont and his M.D. degree at the University of Vermont in 1951. He specializes in obstetrics and gynecology.

Gordon W. Eller, M.D., 9th and Edmond, St. Joseph, has become a member of Buchanan County Medical Society. Dr. Eller is a native of Beloit, Kan. and received his M.D. degree at the University of Kansas in 1969. He specializes in orthopedic surgery.

David Ellis, M.D., 216 S. Kingshighway, St. Louis, has become a member of St. Louis Medical Society. Dr. Ellis is a native of Missouri, received his preliminary education at the University of Illinois and his M.D. degree at the University of Missouri in 1969. He specializes in general surgery.

James M. Epstein, M.D., 114 N. Taylor, St. Louis, has become a member of St. Louis Medical Society. Dr. Epstein is a native of St. Louis, received his preliminary education at the University of Notre Dame and his M.D. degree at Washington University in 1969. He specializes in internal medicine.

Romulo J. Fajatin, M.D., 2 Westbury, St. Charles, has become a member of St. Charles-Lincoln County Medical Society. Dr. Fajatin is a native of the Philippines, received his preliminary education at the University of Santo Tomas and his M.D. degree at the University of Santo Tomas in 1968. He specializes in internal medicine.

James S. Floerchinger, M.D., St. Charles Clinic, St. Charles, has become a member of St. Charles-Lincoln County Medical Society. Dr. Floerchinger is a native of St. Louis, received his preliminary education at Colorado College and his M.D. degree at Washington University in 1965. He specializes in ophthalmology.

Eduardo Garcia-Ferrer, M.D., 1420 Grattan, St Louis, has become a member of St. Louis Medica Society. Dr. Garcia-Ferrer is a native of Cuba an received his M.D. degree at Havana University i 1952. He specializes in psychiatry.

Guillermo Geisse, M.D., Barnes Hospital Plaza St. Louis, has become a member of St. Louis Medical Society. Dr. Geisse is a native of Chile, receive his preliminary education at Colegio San Ignaci and his M.D. degree at Catholic University i 1965. He specializes in radiology.

Marye H. Godinez, M.D., Barnes Hospital Plaza St. Louis, has become a member of St. Louis Med ical Society. Dr. Godinez is a native of Kentucky, received her preliminary education at Gonzaga University and her M.D. degree at St. Louis University in 1971. She specializes in anesthesiology.

Alberto Goldgaber, M.D., 3720 Washington, St. Louis, has become a member of St. Louis Medical Society. Dr. Goldgaber is a native of Brazil, received his preliminary education at Colegio Bittencourt Silva and his M.D. degree at Faculdade de Medicina-Federal Fluminense in 1960. He specializes in internal medicine.

David Goldring, M.D., 500 S. Kingshighway, St. Louis, has become a member of St. Louis Medical Society. Dr. Goldring is a native of Russia, received his preliminary education at Washington University and his M.D. degree at Washington University in 1940. He specializes in pediatrics.

Joseph Hanaway, M.D., Barnes Hospital Plaza, St. Louis, has become a member of St. Louis Medical Society. Dr. Hanaway is a native of New York, received his preliminary education at McGill University and his M.D. degree at McGill University in 1960. He specializes in neurology.

B. K. Hartman, M.D., 4940 Audubon, St. Louis, has become a member of St. Louis Medical Society. Dr. Hartman is a native of Kansas, received his preliminary education at the University of Kansas and his M.D. degree at Kansas University in 1966. He specializes in psychiatry.

Richard Hellman, M.D., 2411 Holmes, Kansas City, has become a member of Jackson County Medical Society. Dr. Hellman is a native of Bronx, N. Y., received his preliminary education at New York University and his M.D. degree at Chicago Medical School in 1966. He specializes in internal medicine.

Albert E. Hesker, M.D., 2821 N. New Ballas Rd., St. Louis, has become a member of St. Louis Medical Society. Dr. Hesker is a native of St. Louis, received his preliminary education at the University of Missouri-Columbia and his M.D. degree at the University of Missouri in 1964. He specializes in radiology.

Thomas W. Hilgers, M.D., 1325 S. Grand, St. Louis, has become a member of St. Louis Medical Society. Dr. Hilgers is a native of Minnesota and received his preliminary education at St. John's University and his M.D. degree at the University of Minnesota in 1969. He specializes in obstetrics and gynecology.

Paul A. Hinds, M.D., Taylor Health Clinic, Southwest Missouri State University, Springfield, has become a member of Greene County Medical Society. Dr. Hinds is a native of Arkansas, received his preliminary education at Drury College and his M.D. degree at the University of Louisville in 1953. He is a clinic physician.

John D. Hirsch, M.D., 216 S. Kingshighway, St. Louis, has become a member of St. Louis Medical Society. Dr. Hirsch is a native of St. Louis, received his preliminary education at Case Western Reserve University and his M.D. degree at Washington University in 1973. He is a resident in surgery.

Charles P. Hughes, M.D., 660 S. Euclid, St. Louis, has become a member of St. Louis Medical Society. Dr. Hughes is a native of Georgia, received his preliminary education at Yale University and his M.D. degree at Case Western Reserve in 1964. He specializes in neurology.

Morris Joftus, M.D., 4652 Maryland, St. Louis, has become a member of St. Louis Medical Society. Dr. Joftus is a native of Illinois, received his preliminary education at Northwestern University and his M.D. degree at the University of Illinois in 1967. He specializes in internal medicine.

George L. Johnson, M.D., Medical Tower, Springfield, has become a member of Greene County Medical Society. Dr. Johnson is a native of Batesville, Ark., received his preliminary education at Southwest Missouri State University and his M.D. degree at Temple University in 1953. He specializes in surgery.

Young M. Kang, M.D., 2415 N. Kingshighway, St. Louis, has become a member of St. Louis Medical Society. Dr. Kang is a native of Korea, received his preliminary education at Seoul National University and his M.D. degree at Seoul National University in 1962. He specializes in general surgery.

Moon Y. Kim, M.D., 1325 S. Grand, St. Louis, has become a member of St. Louis Medical Society. Dr. Kim is a native of Korea, received his preliminary education at Chonnam University and his M.D. degree at Chonnam University in 1966. He specializes in anesthesiology.

Doyle D. Kinder, M.D., 1211 S. Glenstone, Springfield, has become a member of Greene County Medical Society. Dr. Kinder is a native of Sturkie, Ark., received his preliminary education at Little Rock University and his M.D. degree at the

University of Arkansas in 1969. He is in general practice.

George H. Klinkerfuss, M.D., 406 Professional Bldg., Springfield, has become a member of Greene County Medical Society. Dr. Klinkerfuss is a native of St. Louis, received his preliminary education at Washington University and his M.D. degree at Washington University in 1954. He specializes in neurology.

Barbara R. Krupin, M.D., Barnes Hospital Plaza, St. Louis, has become a member of St. Louis Medical Society. Dr. Krupin is a native of Minnesota, received her preliminary education at the University of Minnesota and her M.D. degree at the University of Minnesota in 1968. She specializes in anesthesiology.

Theodore Krupin, M.D., 660 S. Euclid, St. Louis, has become a member of St. Louis Medical Society. Dr. Krupin is a native of St. Louis, received his preliminary education at Washington University and his M.D. degree at St. Louis University in 1968. He specializes in ophthalmology.

Albert Lam, M.D., Barnes Hospital Plaza, St. Louis, has become a member of St. Louis Medical Society. Dr. Lam is a native of China, received his preliminary education at Siena College and his M.D. degree at Albany Medical College in 1970. He specializes in general surgery.

Daniel J. Leary, Jr., M.D., 615 S. New Ballas Rd., St. Louis, has become a member of St. Louis Medical Society. Dr. Leary is a native of Missouri, received his preliminary education at St. Louis University and his M.D. degree at Washington University in 1966. He specializes in radiology.

Jong D. Lee, M.D., 568 Claybine, St. Louis, has become a member of St. Louis Medical Society. Dr. Lee is a native of Korea, received his preliminary education at Kyungpook National University and his M.D. degree at Kyungpook University in 1964. He specializes in general surgery.

Il Taik Lim, M.D., 1325 S. Grand, St. Louis, has become a member of St. Louis Medical Society. Dr. Lim is a native of Korea, received his preliminary education at Chonnam National University and his M.D. degree at Chonnam Medical School in 1963. He specializes in anesthesiology.

Robert C. Loynd, M.D., 9124 Lawn Ave., St. Louis, has become a member of St. Louis Medical Society. Dr. Loynd is a native of Pennsylvania, received his preliminary education at St. Louis University and his M.D. degree at St. Louis University in 1969. He is a resident in otolaryngology.

Sarfraz A. Malik, M.D., 6420 Clayton, St. Louis, has become a member of St. Louis Medical Society. Dr. Malik is a native of India, received his preliminary education at Government College and his M.D. degree at Nishtar Medical College in 1965. He is a resident in internal medicine.

Thomas S. Manion, M.D., 1515 Truman Rd., Independence, has become a member of Jackson County Medical Society. Dr. Manion is a native of St. Paul, Minn., received his preliminary education at St. John's University and his M.D. degree at Creighton University in 1967. He specializes in urology.

David S. Martin, M.D., 7271 Lyndover, Apt. 9, St. Louis, has become a member of St. Louis Medical Society. Dr. Martin is a native of Iowa, received his preliminary education at the Universit of Illinois and his M.D. degree at Abraham Lincol School in 1974. He is an intern.

M. H. Modjtehedy, M.D., 2601 N. Whittier, St Louis, has become a member of St. Louis Medica Society. Dr. Modjtehedy is a native of Iran, received his preliminary education at Migh Schoo and his M.D. degree at Tabriz University in 1969 He specializes in general surgery.

Mahmoud M. Nourbakhsh, M.D., Platte Medica Clinic, Platte, has become a member of Clay County Medical Society. Dr. Nourbakhsh is a native o Iran and received his M.D. degree at the Universit of Tehran in 1961. He specializes in general surgery.

Oscar P. Orille, M.D., 1320 Market, St. Louis has become a member of St. Louis Medical Society Dr. Orille is a native of the Philippines, receive his preliminary education at the University of Sant Tomas and his M.D. degree at the University o Santo Tomas in 1965. He specializes in urology.

Kun H. Park, M.D., 2601 N. Whittier, St. Loui has become a member of St. Louis Medical Society Dr. Park is a native of Korea, received his prelim nary education at Catholic Medical College an his M.D. degree at Catholic Medical College i 1968. He is an intern.

Krikor O. Partamian, M.D., 9th & Edmond, S Joseph, has become a member of Buchanan Count Medical Society. Dr. Partamian is a native Aleppo, Syria, received his preliminary educatio t the University of Beirut and his M.D. degree at he University of Beirut in 1968. He specializes in rology.

Mark S. Ravis, M.D., 1734 E. 63rd, Kansas City, as become a member of Jackson County Medical ociety. Dr. Ravis is a native of Chicago, Ill., reeived his preliminary education at the University f California and his M.D. degree at the University f Missouri in 1973. He is in general practice.

John W. Redmond, M.D., 1325 S. Grand, St. ouis, has become a member of St. Louis Medical ociety. Dr. Redmond is a native of Illinois, reeived his preliminary education at St. Louis Uniersity and his M.D. degree at St. Louis University 1972. He is a resident in ophthalmology.

Rizalina Rodas, M.D., 2700 Hospital Dr., Kansas ity, has become a member of Clay County Medial Society. Dr. Rodas is a native of Manila, Philipines, received her preliminary education at the niversity of Santo Tomas and her M.D. degree at anto Tomas University in 1959. She specializes in ediatrics.

James C. Russell, M.D., 9460 E. 63rd, Kansas ity, has become a member of Jackson County edical Society. Dr. Russell is a native of Wilmingon, Del., received his preliminary education at the niversity of Missouri and his M.D. degree at the niversity of Missouri in 1971. He is in the general ractice of medicine.

Milind Sanwardeker, M.D., 2600 6th St. S.W., anton, Ohio, has become a member of St. Louis edical Society. Dr. Sanwardeker is a native of dia, received his preliminary education at . Wadia College and his M.D. degree at B. J. edical College in 1968. He specializes in internal edicine.

K. H. Sehra, M.D., 5400 Arsenal, St. Louis, has ecome a member of St. Louis Medical Society. Dr. ehra is a native of India, received her preliminary ducation at Intermediate College Science and her .D. degree at Stanley Medical College in 1952. he specializes in psychiatry.

Richard S. Steffens, Jr., M.D., 3701 Woodland r., Columbia, has become a member of Boone ounty Medical Society. Dr. Steffens is a native of leveland, Ohio, received his preliminary education the University of Missouri-Kansas City, and his .D. degree at the University of Missouri-Columa in 1971. He specializes in radiology.

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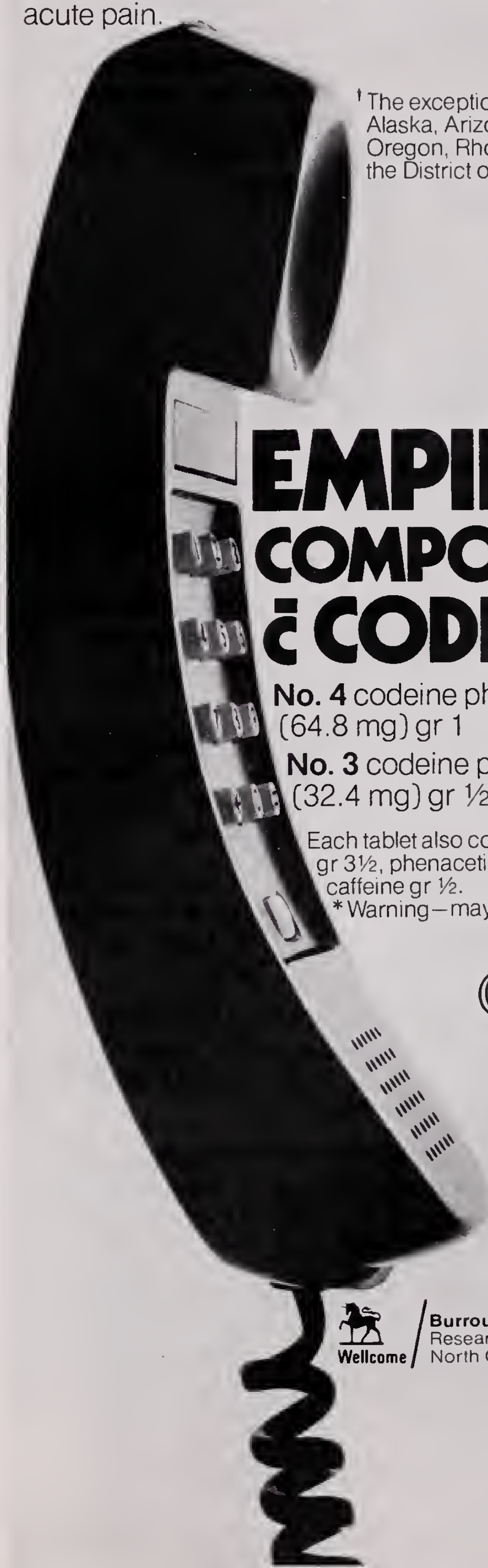

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David M. Van Hook, M.D., 4320 Wornall Rd., Kansas City, has become a member of Jackson County Medical Society. Dr. Van Hook is a native of Springfield, received his preliminary education at the University of Missouri and his M.D. degree at the University of Missouri in 1966. He specializes in orthopedic surgery.

Gary S. Wasserman, D.O., 24th and Gillham Rd., Kansas City, has become a member of Jackson County Medical Society. Dr. Wasserman is a native of Brooklyn, N. Y., received his preliminary education at Albright College and his D.O. degree at Kansas City College of Osteopathy Medicine in 1971. He specializes in pediatrics.

James R. Wiant, M.D., John Cochran VA Hospital, St. Louis, has become a member of St. Louis County Medical Society. Dr. Wiant is a native of Newark, N. J., received his preliminary education at Princeton University and his M.D. degree at Jefferson Medical College in 1959. He specializes in internal medicine.

Thomas J. Young, M.D., 1817 N. Belt, St. Joseph, has become a member of Buchanan County Medical Society. Dr. Young is a native of Inglewood, Calif., received his preliminary education at Kansas City Junior College and his M.D. degree at the University of Missouri in 1967. He specializes in ophthalmology.

In Memoriam

Esther E. L. Coffman, M.D., Lakeworth, Fla., a graduate of National University of Arts and Science, 1917; member of Ozarks County Medical Society; age 82; died April 8, 1974.

Charles H. Eyermann, M.D., 4259 Flora, St. Louis, a graduate of St. Louis University, 1911; member of St. Louis Medical Society; age, 85; died Aug. 31, 1974.

Grover B. Liese, M.D., 1316 Arizona N. E., Albuquerque, N. M., a graduate of the University of Heidelberg, 1915; member of St. Louis Medical Society; age, 86; died Sept. 15, 1974.

Solon P. Harris, M.D., 7138 Maryland Ave., St. Louis, a graduate of the College of Physicians and Surgeons, 1923; member of St. Louis Medical Society; age, 83; died Sept. 17, 1974.

Helmuth H. Kramolowsky, M.D., 7909 Camelot La., St. Louis, a graduate of St. Louis University, 1911; member of St. Louis Medical Society; age, 85; died Sept. 28, 1974.

Saul H. Maizus, M.D., 40 N. Kingshighway Blvd., St. Louis, a graduate of the University of Illinois, 1923; member of St. Louis Medical Society; age 86; died Oct. 21, 1974.

Charles E. Nickson, Jr., M.D., 10901 Winner Rd., Independence, a graduate of the University of Louisville, 1932; member of Jackson County Medical Society; age 69; died Oct. 24, 1974.

Paul C. Quistgard, M.D., Star Route, Box 63 Hollister, a graduate of Northwest University, 1929 member of Jackson County Medical Society; ag 69; died Oct. 28, 1974.

William R. Jackson, M.D., Vine & First, Maryville, a graduate of the University of Louisville 1930; member of Northwest Missouri Medical Society; age 70; died Oct. 29, 1974.

Vincent L. Jones, M.D., 634 N. Grand Blvd., St Louis, a graduate of St. Louis University, 1914 member St. Louis Medical Society; age 86; die Oct. 29, 1974.

Lilborn C. Boemer, M.D., 49 Clermont La., S Louis, a graduate of the St. Louis University, 192 member of St. Louis Medical Society; age 75; die Nov. 7, 1974.

Walter E. Koppenbrink, Jr., M.D., 1712 Mai Higginsville, a graduate of Washington Universit 1945; member of Lafayette-Ray County Medic Society; age 54; died Nov. 13, 1974.

Richard E. Hanna, M.D., 539 Westview, S Louis, a graduate of Washington University, 194 member of St. Louis Medical Society; age 52; die Dec. 1, 1974.

Francis J. Medler, M.D., 9037 McKnight, S Louis, a graduate of St. Louis University, 192 member of St. Louis Medical Society; age 75; di Dec. 2, 1974.

LEO H. POLLOCK, M.D.

Missouri Medicine in Review

ORTY YEARS AGO

Ye Ed of this column expresses his thanks to the brarian, Ms. Algernissen, and to the library of the niversity of Missouri School of Medicine in Kans City for making available the reference jourls used in preparing these historical columns.

In November, 1934, it was announced that Dr. illiam H. Park, long-time director of the research boratories of the New York City Health Departent, had produced a serum made from the spinal ord of monkeys which was effective in immunizing ildren against poliomyelitis. This was accepted idely as the culmination of a long research in the evention of infantile paralysis. In 1910, Dr. Simon exner of the Rockefeller Institute announced that had discovered the virus which causes the disse. Last year, Dr. Maurice Brodie of Manhattan d Dr. Arthur Roland Elvidge of McGill Univery proved that the virus travelled up the olfactory rve to the brain, thence to the spine—a contention Dr. Flexner's.

In a search for a serum more practical and more liable than that obtained from the blood of perns who had been afflicted with the disease, Dr. odie, working with Dr. Park, discovered that a ccine made from the spinal column of infected onkeys would immunize other monkeys.

After testing the vaccine on themselves and labatory associates, 24 children were inoculated and, er, 48 more children were inoculated.

All proved to be immune to poliomyelitis. Inntile paralysis was first recognized as a district sease in 1784 in England. The first known case the United States was in 1841. The first epidemic the country occurred in Vermont with 132 cases 1894. In 1907 and 1908, there were 2,000 cases d 130 deaths in New York City. In 1916, there were 7,130 deaths among children in the United States. Mortality rates run as high as 30%.

TWENTY-FIVE YEARS AGO

Vincent T. Williams, M.D. of Kansas City writes about the history of the MSMA as follows:

"On November 4, 1850, 98 physicians from St. Louis and 38 from other localities in the state met and organized the Missouri State Medical Association. Dr. George Penn, St. Louis County, acted as temporary President until the following officers were elected: President, Dr. F. W. G. Thomas, Boonville; Vice-Presidents, Drs. J. Barnes, St. Louis; B. F. Coulter, Pike County; H. T. Hughes, Lewis County; J. Wood, Clay County; J. F. Atkinson, Lafayette County; Secretaries, Drs. H. C. Wright, Warren County; and J. S. B. Alleyne, St. Louis; Treasurer, Dr. G. Johnson, St. Louis.

"Most of the meetings were held in St. Louis until 1872, although Boonville entertained the Association in 1850, Lexington in 1854 and 1856 and St. Joseph in 1857. In 1872, it was decided that the objects of the Association could be accomplished more effectively and a greater number of physicians in the state brought within its sphere of influence if the annual meetings were held in different sections of the state."

TEN YEARS AGO

The Johnson-Humphrey landslide victory at the polls in November still dominates the nation's political conversation as the old year gives way to the new. Most of the so-called experts agree that with the Democrats holding their largest congressional majority in 28 years, Social Security "Medicare" is much closer to reality than it has ever been before. This does not mean, however, that King-Anderson-type legislation is a certainty.

A veteran employee of the MSMA, Miss Helen Penn, retired on Jan. 1, 1965 after completing 34 years of service with the organization. Miss Penn joined the executive office staff in 1930 when the late Edward J. Goodwin, M.D. was full-time secretary of the Association and Editor of Missouri Medicine. She served as Dr. Goodwin's assistant in both capacities.

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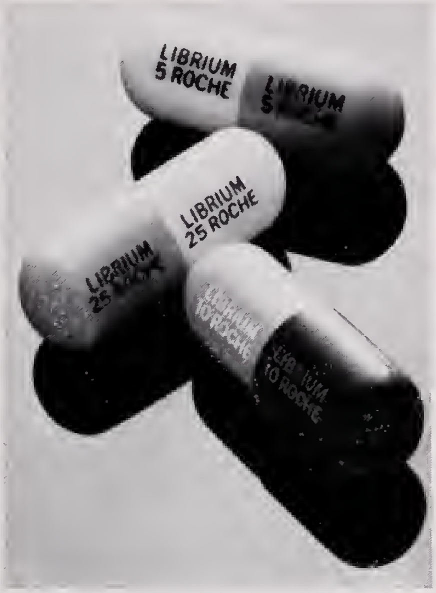
INJECTABLE: Keep patients under observa- n, preferably in bed, up to three hours after itial injection; forbid ambulatory patients to erate vehicle following injection; do not dminister to patients in shock or comatose ates; use reduced dosage (usually 25 to 50 g) for the elderly or debilitated and for ildren age twelve or older.
ORAL AND INJECTABLE: Though generally t recommended, if combination therapy ith other psychotropics seems indicated, refully consider individual pharmacologic fects, particularly in use of potentiating mpounds such as MAO inhibitors and enothiazines. Observe usual precautions in esence of impaired renal or hepatic func- n. Paradoxical reactions (e.g., excitement, imulation and acute rage) have been ported in psychiatric patients and hyper- ctive aggressive children. Employ usual



precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.
Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.
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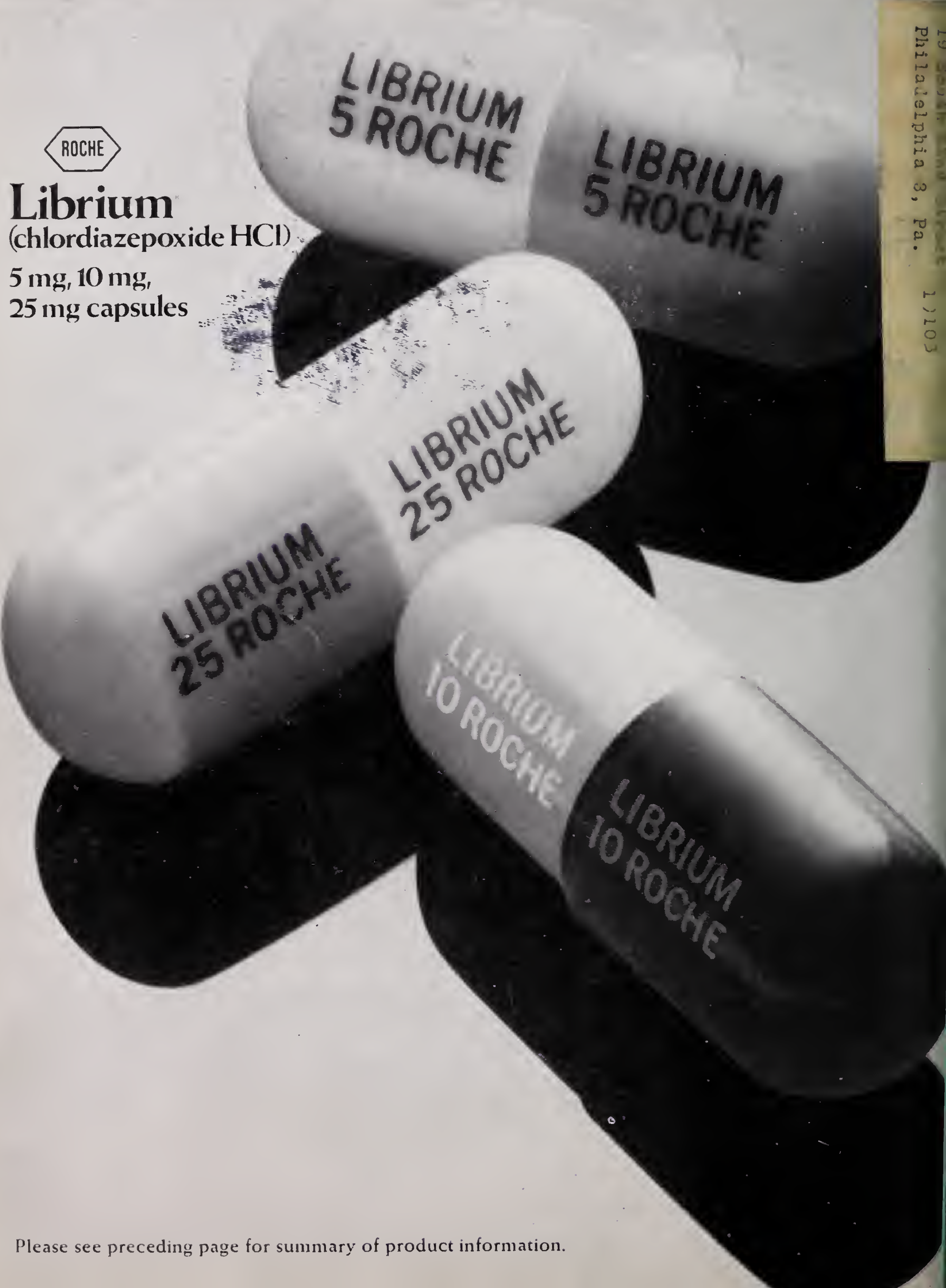
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117th MSMA Annual Session
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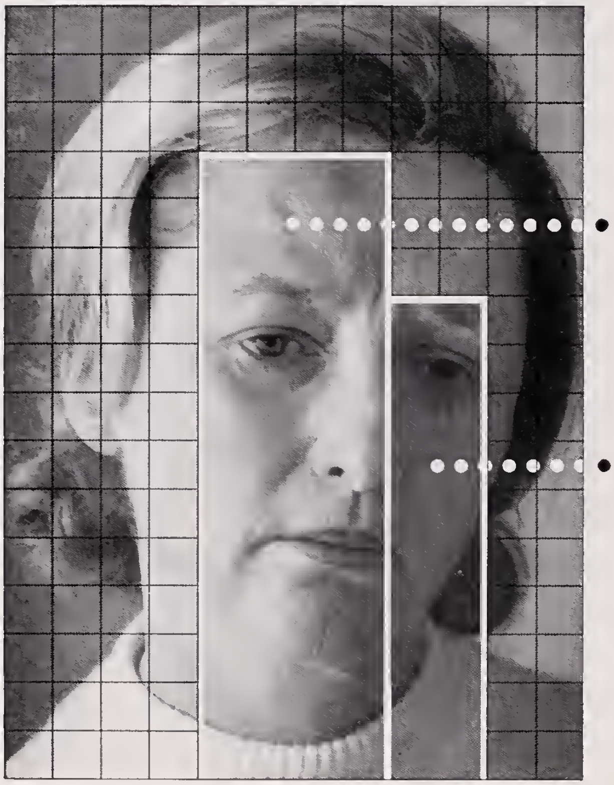
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and/or severity of grand mal seizu
require increased dosage of standa
convulsant medication; abrupt wit
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seizures. Advise against simultane
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n is pronounced and
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nent is usually apparent
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in psychoneurotic
anxiety states
with associated
depressive symptoms

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cy, lactation or women of child-
age, weigh potential benefit
possible hazard.
ions: If combined with other psy-
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s, barbiturates, MAO inhibitors
r antidepressants may potentiate
n. Usual precautions indicated in
severely depressed, or with latent
ion, or with suicidal tendencies.
Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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not if the vasodilator is

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The cerebral or peripheral vascular disease patient often has coexisting disease[1] which calls for another drug along with his vasodilator. It may be a hypoglycemic, miotic, antihypertensive, diuretic, anticoagulant, corticosteroid, or coronary vasodilator.

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In fact, there are no known contraindications to the use of Vasodilan in recommended oral doses, other than that it should not be given in the presence of frank arterial bleeding or immediately postpartum.

1. Gertler, M. M., et al.: Geriatrics *25*.134-148 (May) 1970.

Indications: Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows:

Possibly Effective:

1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.
3. Threatened abortion.

Final classification of the less-than-effective indications requires further investigation.

Composition: Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg.

Dosage and Administration: 10 to 20 mg. three or four times daily.

Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

Adverse Reactions: On rare occasions, oral administration of the drug has been associated in time with the occurrence of severe rash. When rash appears, the drug should be discontinued. Occasional overdosage effects such as transient palpitation or dizziness are usually controlled by reducing the dose.

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Other: Hypoglycemia, CNS stimulation, jaundice.

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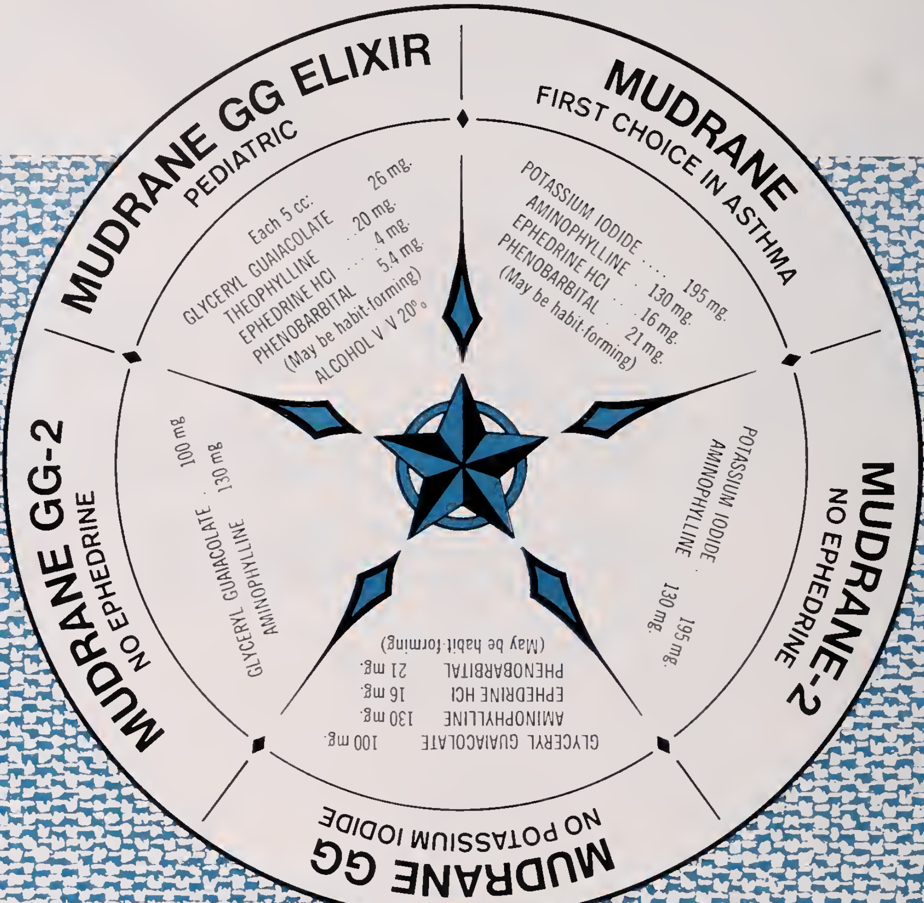
The MUDRANES

Discreet formulations of four well regarded drugs for the relief of bronchial distress—Potassium Iodide, Glyceryl Guaiacolate, Aminophylline, Ephedrine with Phenobarbital (to lessen cardiac stimulation).



MUDRANE
FIRST CHOICE IN ASTHMA
POTASSIUM IODIDE .... 195 mg.
AMINOPHYLLINE . 130 mg.
EPHEDRINE HCl . 16 mg.
PHENOBARBITAL . 21 mg.
(May be habit-forming)
MUDRANE-2
NO EPHEDRINE
POTASSIUM IODIDE . 195 mg.
AMINOPHYLLINE 130 mg.
MUDRANE GG
NO POTASSIUM IODIDE
GLYCERYL GUAIACOLATE 100 mg.
AMINOPHYLLINE 130 mg.
EPHEDRINE HCl 16 mg.
PHENOBARBITAL 21 mg.
(May be habit-forming)
MUDRANE GG-2
NO EPHEDRINE
GLYCERYL GUAIACOLATE . 100 mg
AMINOPHYLLINE 130 mg
MUDRANE GG ELIXIR
PEDIATRIC
Each 5 cc:
GLYCERYL GUAIACOLATE 26 mg.
THEOPHYLLINE . 20 mg.
EPHEDRINE HCl .... 4 mg.
PHENOBARBITAL 5.4 mg.
(May be habit-forming)
ALCOHOL V V 20%

INDICATIONS: For the prompt symptomatic relief of bronchial asthma, emphysema and bronchiectasis. The Mudranes dilate the bronchi and liquefy mucus plugs. DOSAGE: Tablet; One tablet with a full glass of water 3 or 4 times daily as required. Divide tablet for child's dose. Elixir; Children, 1 cc for each 10 lbs. of body weight. May be repeated 3 or 4 times a day. Adult, one tablespoonful 4 times daily. All doses should be followed with a glass of water.

CONTRAINDICATIONS: Aminophylline/Theophylline is contraindicated in the presence of severe cardiac arrhythmias and patients with massive myocardial damage. Ephedrine, in presence of severe heart disease, extreme hypertension, and in hyperthyroidism. Phenoharbital, in porphyria and in patients with known phenobarbital sensitivity. Potassium Iodide, in pregnancy (to protect the fetus against possible iodine-induced depression of thyroid activity), in tuberculosis (produces gumma dissolution), and in acne; also in the presence of known iodide sensitivity. PRECAUTIONS: Aminophylline/Theophylline should be avoided in patients with massive myocardial damage and/or severe cardiac arrhythmias. In children, overdose may cause vomiting, cardiac arrhythmias, and severe agitation. Ephedrine should be used with caution in the presence of severe cardiac disease, particularly arrhythmias and angina pectoris; avoid in hyperthyroidism and severe hypertension. Phenobarbital may be habit-forming. Avoid overdosage. Potassium Iodide: Discontinue in the presence of skin rash, swelling of the eyelids and severe frontal headache. Long use may cause goiter. ADVERSE REACTIONS: Aminophylline/Theophylline may cause nausea, cardiac arrhythmias, and aggravate severe myocardial disease. It may cause headaches and tachycardia. Vomiting and dizziness are not uncommon. Ephedrine: In patients hypersensitive to CNS stimulation, ephedrine may cause nervousness, tachycardia, extrasystole and ventricular arrhythmias. May cause urinary retention, especially in the presence of partial prostatic obstruction. Psychoneurosis may be aggravated. Pre-existing anginal pain will be aggravated. Phenobarbital may produce severe skin rash. Avoid overdosage. May be habit-forming. Potassium Iodide may cause nausea. Over very long period of use, iodides cause goiter. Discontinue if patient develops skin rash, eye irritation, eyelid swelling, or severe frontal headache.

HOW SUPPLIED: Mudrane and Mudrane GG available in bottles of 100 and 1000 tablets; Mudrane-2 and Mudrane GG-2 in 100s; Elixir in pints and half-gallons.

Federal law prohibits dispensing without prescription.

WILLIAM P. POYTHRESS & COMPANY, INC., RICHMOND, VIRGINIA 23261

MSMA

NEWS ROUND - UP

FEBRUARY, 1975

General Assembly off to fast start

The 78th Missouri General Assembly is off to a rousing start with more than 1,200 bills alady introduced for consideration.

To date, the MSMA staff has tagged 28 Senate bills and 76 House bills which will be folwed by various degrees due to their possible impact upon the practice of medicine.

The MSMA Legislative Committee will present its recommendations on current legislation fore the MSMA Council at the Council's February 8 meeting in Jefferson City.

Many of the bills, although introduced, have not been printed as of now. Therefore, final cisions cannot be made until the bills are studied.

Some of the Senate bills which will rate individual attention of the Legislative Committee clude measures which would license free-standing surgicenters, establish the office of medal examiner to replace coroners, provide insurance coverage for mental and alcoholic condins and others which would affect the practice acts of the various health professions.

The lengthy House list includes bills which would permit printing of the Uniform Anatomil Gift Act on the reverse of vehicle driver's licenses, allow licensing of acupuncturists, exnd the practice of chiropractic, provide for added confidentiality of medical records, extend e statute of limitations in medical liability cases, call for full insurance coverage of materty benefits, require certification of physician assistants and many, many others.

More in-depth legislative information will be published in the March issue of MISSOURI EDICINE after the Legislative Committee and Council have considered the bills and deterined the stands to be taken by the Association.

Diabetes editorial making headlines

The February 10 issue of JAMA will have an icle by a committee of the Biometric Society t reviewed the data and the conclusions of The iversity Group Diabetes Program (UGDP).

The Biometric Society experts conclude that st of the criticism leveled at the UGDP findings unpersuasive and that the proponents of oral perglycemics would have to conduct scientifical adequate studies to justify their continued use of ch agents.

An editorial in the same issue of JAMA by Dr. omas Chalmers, a former employee of NIH, ffirms his opinion that the UGDP conclusions re valid and that the use of oral hyperglycemics probably associated with an increased mortality m cardiovascular events, possibly "10,000 to 000 such unnecessary deaths occurring each r in the United States alone."

Deadline for Resolutions in Handbook is March 1

MSMA members, County Medical Societies and Student Delegates desiring to introduce resolutions at the 1975 Annual Session of the Missouri State Medical Association are reminded that March 1 is the deadline for insertion of resolutions in the Delegates' Handbook.

Any resolution to be introduced after that time must be made available to the House 24 hours before the session in which it is to be introduced and at least 200 copies of the resolution, or funding for same, must be submitted by the sponsor.

The same MSMA Bylaw procedure applies for the Second Session, but introduction requires two-thirds approval. Unanimous approval is needed for introduction at the Final Session.

Proposed MSMA Constitution change

House to decide on 'Unified Membership'

A proposed amendment to the Constitution and Bylaws of the Missouri State Medical Association which would require unified membership in the AMA will come before the MSMA House of Delegates at the 1975 Annual Session.

As outlined in the Constitution, each component society has been informed of the proposed amendment. Also, as required, the proposal is being published in MISSOURI MEDICINE.

Briefly, "Unified Membership in the AMA" means that when a physician joins a county medical society and the Missouri State Medical Association he would also have to join the American Medical Association. Currently, membership in the AMA is optional.

The Committee on Constitution and Bylaws has drawn up suggested language which would become part of the MSMA Constitution if the proposed amendment is approved by the House.

Suggested wording for the proposed amendment:

1. Amend the Constitution of the Missouri State Medical Association by striking out "Article III. Membership" and inserting in lieu thereof the following:

> *"Membership in this Association shall be limited to and include all members in good standing in component societies which hold charters from this Association and who are members in good standing of the American Medical Association."*

2. Amend the Bylaws of the Missouri State Medical Association as follows: Amend "Chapter I. Membership" by striking out all of Section 1 of Chapter I and inserting in lieu thereof the following:

> *"Section 1. Members of this Association shall be physicians whose names have been certified by secretaries of component societies to the Secretary of this Association that they are duly elected members of a component society and are legally qualified physicians practicing in Missouri and are members of the American Medical Association except as otherwise provided. Each member must be of good moral and professional standing, and must not support, nor practice, n claim to practice any exclusive system medicine."*

3. Amend Chapter VIII, Section 1(a) of the B laws by striking out Section 1(a) of Chapter VI and inserting in lieu thereof the following:

> *"Section 1. (a) The annual dues of this Ass ciation shall be $90.00, which shall be app cable to each active member of the Associ tion beginning in 1975 and shall be levied p capita on the active members of the comp nent societies; the per capita levy for juni members shall be $10.00 per year; hon and associate members shall not be requir to pay dues. Dues shall be payable on Janua 1 of the year for which they are levied. A forgiveness of the dues and assessments the AMA shall be in accordance with rul and regulations of that Association."*

4. Amend Chapter VIII, Section 4, of the B laws by striking out Section 4 of Chapter VIII ar inserting in lieu thereof the following:

> *"Section 4. The Secretary of each comp nent society shall cause to be collected ar remitted to the Treasurer of this Associati the dues and capita levies of this Associati and the dues and assessments of the Ame can Medical Association. Any member who name has not been reported for enrollme and whose dues, capita levies of this Ass ciation and dues and assessments of t American Medical Association have not be remitted to the Treasurer of this Associati on or before March 1 of each year sh stand suspended until his name is proper reported and his dues, capita levies and sessments for the current year are paid. December 31 of each year, members deli quent in payment of such dues and asse ments, or any part thereof shall, ipso fac forfeit their memberships. No suspend member shall be eligible to register at an nual session."*

Discussion — The Committee on Consti tion and Bylaws submits the amendments o lined above to implement the unified membersh resolution if it is adopted.

Democrats increase majority; Directories available

The November election resulted in a substantial increase for the Democrats on both the state and national legislative levels. The breakdown follows:

U.S. Senate

Democrats	60
Republicans	37
Conservative	1
Independent	1
Undecided seat	1

U.S. House

Democrats	291
Republicans	144

Missouri Senate

Democrats	23
Republicans	11

Missouri House

Democrats	113
Republicans	50

The MSMA has published a 1975-76 Miss Legislative Directory listing the names and dresses of both state and federal lawmakers. copy of the Directory can be obtained by writ MSMA Headquarters.

Regulations opposed by MSMA

The Department of Health, Education and Welfare was requested to rescind new federal regulations requiring establishment of utilization review mechanisms in hospitals by Feb. 1, 1975.

In a letter to Secretary Caspar W. Weinberger, r. James C. Cope, MSMA President, said the reg- ations, which would be a condition of institution- participation in the Medicare and Medicaid pro- ams, would duplicate existing projects and, erefore, double health care costs in an area here the stated objective is to reduce costs.

Additionally, Dr. Cope pointed out that the me schedule set up for implementation of the gulations (Feb. 1, 1975) was unrealistic and that e majority of Missouri hospitals could not meet e deadline.

Dr. Cope said Missouri physicians are com- itted to utilization review and are working with- the federally-mandated PSRO's to establish ef- ctive review. To embark on the new regulations ould mean setting up a dual system to accomplish e same aim.

The Department of H.E.W. was requested to scind the new regulations and concentrate its ef- rts and funds on the orderly and sound develop- ent of previously-funded PSRO's.

In reply to Dr. Cope's letter, Dr. Michael J. oran, Director of the Bureau of Quality Assur- nce in H.E.W., said that hospitals will be able to quest waivers of the Feb. 1 deadline in order to velop written criteria for the review system. aivers will be granted, Dr. Goran added, when e institution is deemed to be making a good faith fort to comply with development of review cri- ria.

Copies of Dr. Cope's letter were mailed to ch county medical society, the state PSRO sup- rt center, area PSRO's, the AMA and the Mis- uri Congressional Delegation.

Several Congressmen expressed concern in the gulations and informed the MSMA that they will ek further information.

MA special assessment is mailed

The AMA has mailed special assessment lls of $60 to all active AMA members, cept interns, residents and medical stu- nts, as directed by the AMA House of elegates in December.

Payment of the assessment is in addition the billing received from your county or ate association. The $60 payment should made directly to the AMA whereas the gular billing should be paid through your unty society.

Accompanying the assessment billing a letter from AMA Board of Trustees airman Richard E. Palmer, M.D., and a ecial report on the AMA's financial situ- ion.

If further information is desired con- rning the special assessment, contact SMA Headquarters.

Tired miners demand more time for sex

Who says all union demands are unreasonable?

According to an Association Press report from Suva, Fiji, a gold miners' union says their men are too tired after a full day at the diggings to serve their wives properly and the men need a sex break after lunch.

A union spokesman said, "After a day's work, miners are exhausted and in no condition for a healthy sex relationship with their wives by bedtime." If the sex break could be tacked onto the lunch break, however, "a man would be in prime physical condition and ready for his sexual obligations."

The report did not indicate whether the union had also entered into negotiations with the miners' wives.

MMPAC shows well in election

With all the talk we hear about the "disasterous" election year for medicine, it is interesting to note that 88% of the candidates supported by the Missouri Medical Political Action Committee (MMPAC) were successful in the November balloting.

The breakdown in the various races in Missouri include:

U.S. Congress: 8 supported, 7 won — 87%
Missouri Senate: 17 supported, 13 won — 77%
Missouri House: 110 supported, 99 won — 90%

The fact that MMPAC supported candidates does not mean that, after elected, these lawmakers will always vote "for" medicine. However, in selecting candidates to support, MMPAC attempts to find those candidates who will listen to medicine's point of view on the issues.

The post-election report of the American Medical Political Action Committee (AMPAC) show that AMPAC-backed candidates won 22 of 34 U.S. Senate races and 183 of 248 U.S. House races. The winning percentage in the Senate was 63.6% and in the House 73.8%.

AMPAC officials also reported an all-time high in membership in the national organization.

Membership in MMPAC and AMPAC is open to all MSMA members and the importance of a large enrollment has never been greater. The issues facing medicine on both the state and national fronts are increasing annually.

The MMPAC-AMPAC billing was included with your MSMA membership billing. If you have not paid your Association dues, please write a check for MMPAC membership. If you have paid MSMA dues, but did not join MMPAC, please send a separate check for $25 to your county society. Remember, if you are a professional corporation, MMPAC dues should be written on a PERSONAL check!

For further MMPAC information, write MMPAC, Box 755, Jefferson City, Missouri 65101.

(A copy of MMPAC report filed with the appropriate supervisory officer is (or will be) available for purchase from the Superintendent of Documents, United States Government Printing Office, Washington, D.C. 20402.)

Medical news-in-brief

Quality Assurance program

In conjunction with the annual meeting of the Missouri Society of Internal Medicine and the Missouri Chapter of the American College of Physicians, the afternoon of Friday, March 7, will be devoted to a discussion of Quality Assurance.

The meeting is open to all concerned physicians, hospital administrators, nurses, medical records personnel and interested persons. The panel will include representatives of the Department of H.E.W., the Joint Commission on Accreditation of Hospitals, the U.S. Senate, the University of Missouri and the two sponsoring societies.

The meeting will be held from 1:30 p.m. to 5:30 p.m., March 7, at the University of Missouri Medical School in Columbia.

A registration fee of $20 covers all representatives of a hospital. Individuals, physicians and others not representing hospitals will be charged a $5 fee. Along with the ACP and ASIM, the meeting is being co-sponsored by the HCFM/PSRO Support Center.

County Incentive Plan

The AMA will again sponsor a "County Membership Incentive Program" in 1975.

A participating county society will receive one-half of the first year dues of new AMA members. For example, if a society enrolls a new AMA member at $110, the society will receive a $55 rebate. This also applies if a former AMA member whose membership has been terminated for 24 or more months rejoins the AMA.

To qualify for the program, county societies are required to establish a permanent Committee on Membership and actively solicit memberships.

Missouri societies which participated in the program in 1974 were Boone County, Buchanan County, Greene County, Jackson County, Mineral Area, Ozark, St. Louis and St. Louis County.

Dr. Stacey nominated

Wallace R. Stacey, M.D., of Independence, has been nominated to the University of Missouri's Board of Curators by Gov. Christopher S. Bond.

Dr. Stacey is president-elect of the Missouri Obstetrics and Gynecological Society and is district director of the State Cancer Board.

Smoking rules sought

Missouri hospitals will be asked to revise the smoking regulations to prohibit unsupervis smoking by patients.

Dr. Herbert R. Domke, director of the Sta Division of Health, said the ban is needed becau cigarette smoking is the chief cause of hospit fires.

Dr. Domke said he recognizes it may be dif cult for hospitals to enforce the smoking restri tions he will request, but he feels the safety patients justifies whatever efforts are necessa to limit smoking by patients to times and are where supervision can be provided.

Dr. Joseph P. Russell, director of hospit services for the Division, said that records f the last five years show that smoking caused 2 hospital fires, or 71% of the 305 fires reported the Division by hospitals.

In addition, Dr. Russell said stricter standar are needed on the furnishings of patient rooms insure that highly flammable material is not pr ent.

Medicare liability set

Final regulations were issued spelling out c cumstances under which a Medicare beneficia will not be held liable for the costs of non-cover services, and setting forth instances when Me care will accept liability.

Under the regulations published in the *Feder Register:*

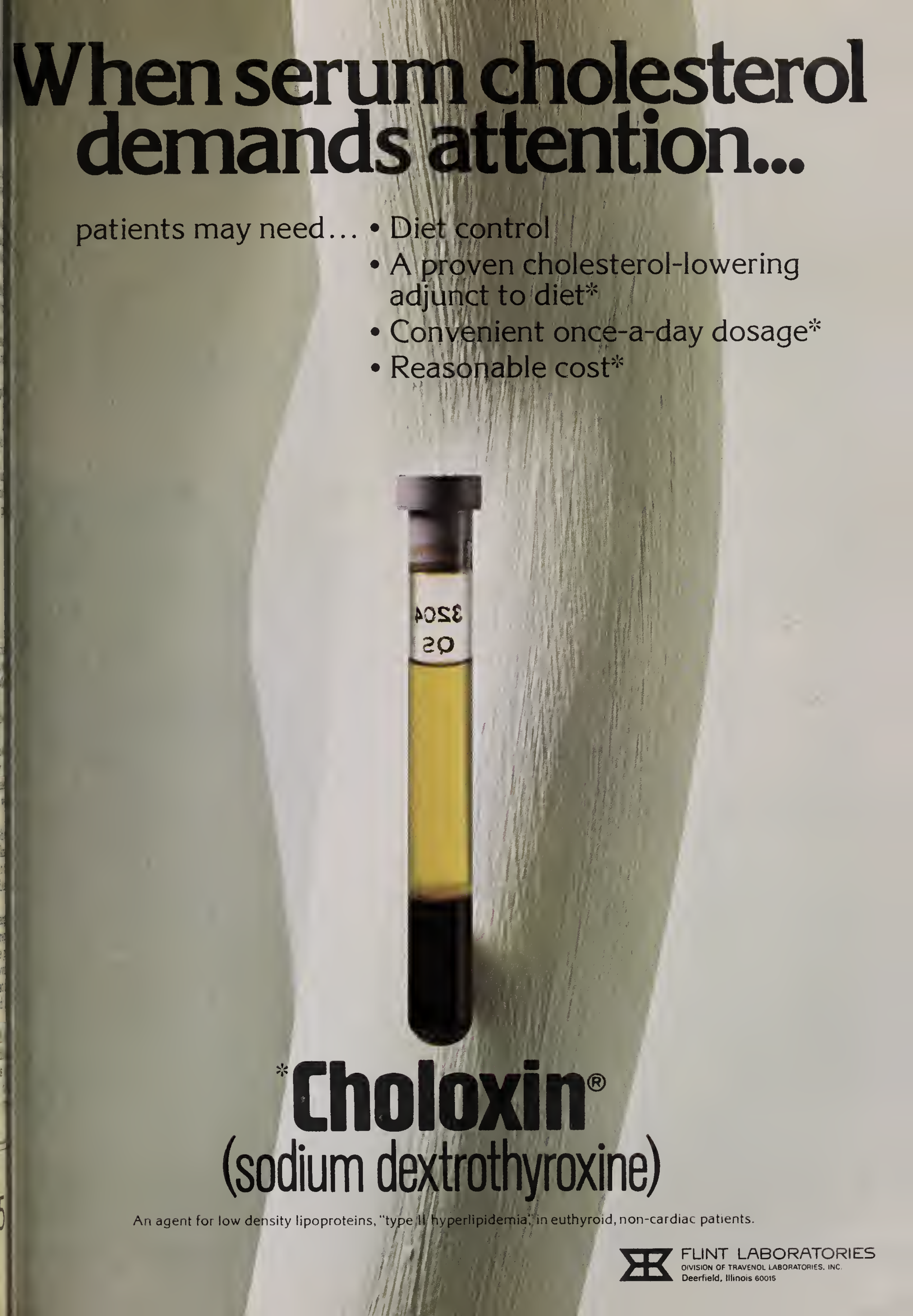
● Medicare will pay for the services if nei er the person who received the services nor t person who furnished them knew, or could reas ably be expected to know, that the services we not covered.

● If the provider of services, or the phy cian or other person in an assignment case, kn or could reasonably be expected to know that t services were not covered, then neither Medica nor the beneficiary will pay.

● If in these cases, the beneficiary is charg for the non-covered service, Medicare will rep the beneficiary and charge the amount to the p vider of services or the physician. The provic or physician will then have the right to contest decision through administrative appeals and courts.

When a provider is found to have made all r sonable efforts to obtain knowledge of Medica and to apply that knowledge, the regulations mit a presumption that the provider did not ha knowledge of non-coverage in a particular ca in the absence of evidence to the contrary.

MSMA Annual Session, April 17-20, 1975



When serum cholesterol demands attention...

patients may need...
- Diet control
- A proven cholesterol-lowering adjunct to diet*
- Convenient once-a-day dosage*
- Reasonable cost*

***Choloxin®**

(sodium dextrothyroxine)

An agent for low density lipoproteins, "type II hyperlipidemia," in euthyroid, non-cardiac patients.

FLINT LABORATORIES
DIVISION OF TRAVENOL LABORATORIES, INC.
Deerfield, Illinois 60015

Choloxin® (sodium dextrothyroxine)

The Lipid-Lowering Agent with Once-A-Day Dosage

Four strengths . . . 1, 2, 4, and 6 mg. . . . are available making the scored tablet regimen a flexible dosage system. And, for most patients, CHOLOXIN tablets offer once-a-day dosage.

AN IMPORTANT NOTE:
It has not been established whether the drug-induced lowering of serum cholesterol or lipid levels has a detrimental, beneficial, or no effect on the morbidity or mortality due to atherosclerosis or coronary heart disease. Several years will be required before current investigations will yield an answer to this question.

CHOLOXIN® (sodium dextrothyroxine) Single-Tablet-A-Day Dosage Schedules

See prescribing information in package insert reproduced below.

	Starting Dosage	Increased Monthly by	Usual Maintenance	Maximal Recommende
Adult Hypercholesterolemic	1.0-2.0 mg.	1.0-2.0 mg.	4.0-8.0 mg.	4.0-8.0 mg.
Pediatric Hypercholesterolemic	0.05 mg./kg. body weight	0.05 mg./kg.	0.1 mg./kg. body weight	4.0 mg.
Hypothyroid Cardiac	0.5-1.0 mg.	1.0 mg.	4.0 mg.	4.0 mg.

Choloxin®
(sodium dextrothyroxine)

Description
CHOLOXIN (sodium dextrothyroxine) is the sodium salt of the dextrorotatory isomer of thyroxine. It is chemically described as D-3,5,3′,5′-tetraiodothyronine sodium salt.

Actions
The predominant effect of CHOLOXIN (sodium dextrothyroxine) is the reduction of serum cholesterol levels in hyperlipidemic patients. Beta lipoprotein and triglyceride fractions may also be reduced from previously elevated levels.

Most of the available evidence indicates that CHOLOXIN stimulates the liver to increase catabolism and excretion of cholesterol and its degradation products via the biliary route into the feces. Cholesterol synthesis is not inhibited and abnormal metabolic endproducts do not accumulate in the blood.

Indications
This is not an innocuous drug. Strict attention should be paid to the indications and contraindications.

CHOLOXIN (sodium dextrothyroxine) is an antilipidemic agent used as an adjunct to diet and other measures for the reduction of elevated serum cholesterol (low density lipoproteins) in euthyroid patients with no known evidence of organic heart disease.

The drug is also indicated in the treatment of hypothyroidism in patients with cardiac disease who cannot tolerate other types of thyroid medication.

Before prescribing, note the following: Results from a randomized clinical study have indicated a possible adverse effect when CHOLOXIN is administered to a patient receiving a digitalis preparation. There may be an additive effect. This additive effect may possibly stimulate the myocardium excessively in patients with significant myocardial impairment. CHOLOXIN dosage should not exceed 4 mg per day when the patient is receiving a digitalis preparation concomitantly. Careful monitoring of the total effect of both drugs is important.

It has not been established whether the drug-induced lowering of serum cholesterol or lipid levels has a detrimental, beneficial, or no effect on the morbidity or mortality due to atherosclerosis or coronary heart disease. Several years will be required before current investigations will yield an answer to this question.

Contraindications
The administration of CHOLOXIN (sodium dextrothyroxine) to euthyroid patients with one or more of the following conditions is contraindicated:

1. Known organic heart disease, including angina pectoris; history of myocardial infarction; cardiac arrhythmia or tachycardia, either active or in patients with demonstrated propensity for arrhythmias; rheumatic heart disease; history of congestive heart failure; and decompensated or borderline compensated cardiac status.
2. Hypertensive states (other than mild, labile systolic hypertension).
3. Advanced liver or kidney disease.
4. Pregnancy.
5. Nursing mothers.
6. History of iodism.

Warnings
CHOLOXIN (sodium dextrothyroxine) may potentiate the effects of anticoagulants on prothrombin time. Reductions of anticoagulant dosage by as much as 30% have been required in some patients. Consequently, the dosage of anticoagulants should be reduced by one-third upon initiation of CHOLOXIN therapy and the dosage subsequently readjusted on the basis of prothrombin time. The prothrombin time of patients receiving anticoagulant therapy concomitantly with CHOLOXIN therapy should be observed as frequently as necessary, but at least weekly, during the first few weeks of treatment.

In the surgical patient, it is wise to consider withdrawal of the drug two weeks prior to surgery if the use of anticoagulants during surgery is contemplated.

When CHOLOXIN is used as thyroid replacement therapy in hypothyroid patients with concomitant coronary artery disease (especially those with a history of angina pectoris or myocardial infarction) or other cardiac disease, treatment should be initiated with care. Special consideration of the dosage schedule of CHOLOXIN is required. This drug may increase the oxygen requirements of the myocardium, especially at high dosage levels. Treated subjects with coronary artery disease must be seen at frequent intervals. If aggravation of angina or increased myocardial ischemia, cardiac failure, or clinically significant arrhythmia develops during the treatment of hypothyroid patients, the dosage should be reduced or the drug discontinued.

Special consideration must be given to the dosage of other thyroid medications used concomitantly with CHOLOXIN. As with all thyroactive drugs, hypothyroid patients are more sensitive to a given dose of CHOLOXIN than euthyroid patients.

Epinephrine injection in patients with coronary artery disease may precipitate an episode of coronary insufficiency. This condition may be enhanced in patients receiving thyroid analogues. These phenomena should be kept in mind when catecholamine injections are required in sodium dextrothyroxine-treated patients with coronary artery disease.

Since the possibility of precipitating cardiac arrhythmias during surgery may be greater in patients treated with thyroid hormones, it may be wise to discontinue CHOLOXIN in euthyroid patients at least two weeks prior to an elective operation. During emergency surgery in euthyroid patients, and in surgery in hypothyroid patients in whom it may be advisable to withdraw therapy, the patients should be carefully observed.

There are reports that sodium dextrothyroxine in diabetic patients is capable of increasing blood sugar levels with a resultant increase in requirements of insulin or oral hypoglycemic agents. Special attention should be paid to parameters necessary for good control of the diabetic state in dextrothyroxine-treated subjects and to dosage requirements of insulin or other antidiabetic drugs. If sodium dextrothyroxine is later withdrawn from patients who had required an increase of insulin (or oral hypoglycemic agents) dosage during its administration, the dosage of antidiabetic drugs should be reduced and adjusted to maintain good control of the diabetic state.

When either or both impaired liver or kidney function are present, the advantages of CHOLOXIN therapy must be weighed against the possibility of deleterious results.

Usage in Women of Childbearing Age
Women of childbearing age with familial hypercholesterolemia or hyperlipemia should not be deprived of the use of this drug; it can be given to those patients exercising strict birth control procedures. Since pregnancy may occur despite the use of birth control procedures, administration of CHOLOXIN (sodium dextrothyroxine) to women of this age group should be undertaken only after weighing the possible risk to the fetus against the possible benefits to the mother. Teratogenic studies in two animal species have resulted in no abnormalities in the offspring.

Precautions
It is expected that patients on dextrothyroxine therapy will show greatly increased serum protein-bound-iodine levels. These increased serum PBI values are evidence of absorption and transport of the drug, and should NOT be interpreted as evidence of hypermetabolism; similarly, they may not be used for titrating the effective dose of CHOLOXIN (sodium dextrothyroxine). PBI values in the range of 10 to 25 mcg% in treated patients are common.

If signs or symptoms of iodism develop during CHOLOXIN therapy, the drug should be discontinued.

A few children with familial hypercholesterolemia have been treated with CHOLOXIN for periods of one year or longer with no adverse effects on growth. However, it is recommended that the drug be continued in patients in this age group only if a significant serum cholesterol-lowering effect is observed.

Adverse Reactions
The side effects attributed to dextrothyroxine therapy are, for the most part, due to increased metabolism, and may be minimized by following the recommended dosage schedule. Adverse effects are least commonly seen in euthyroid patients with no signs or symptoms of organic heart disease; the incidence of adverse effects is increased in hypothyroid patients, and is highest in those patients with organic heart disease superimposed on the hypothyroid state.

In the absence of known organic heart disease, some cardiac changes may be precipitated during sodium dextrothyroxine therapy. In addition to angina pectoris, arrhythmia consisting of extrasystoles, ectopic beats, or supraventricular tachycardia, ECG evidence of ischemic myocardial changes and increase in heart size have been observed. Myocardial infarctions, both fatal and non-fatal, have occurred, but these are not unexpected in untreated patients in the age groups studied. It is not known whether any of these infarcts were drug related.

Changes in clinical status that may be related to the metabolic action of the drug include the development of insomnia, nervousness, palpitations, tremors, loss of weight, lid lag, sweating, flushing, hyperthermia, hair loss diuresis, and menstrual irregularities Gastrointestinal complaints durin therapy have included dyspepsia, nausea and vomiting, constipation, diarrhea, and decrease in appetite.

Other side effects reported to b associated with CHOLOXIN (sodiu dextrothyroxine) therapy include th development of headache, changes i libido (increase or decrease), hoarseness, tinnitus, dizziness, periphera edema, malaise, tiredness, visual disturbances, psychic changes, paresthesia, muscle pain, and various bizarr subjective complaints. Skin rashes, including a few which appeared to b due to iodism, and itching have bee attributed to dextrothyroxine by som investigators. Gallstones have bee discovered in occasional dextrothyroxine-treated patients and cholestati jaundice has occurred in one patien although its relationship to CHOLOXI therapy was not established.

In several instances, the previousl existing conditions of the patient appeared to continue or progress durin the administration of CHOLOXIN; worsening of peripheral vascular disease, sensorium, exophthalmos, an retinopathy have been reported.

CHOLOXIN potentiates the effects c anticoagulants, such as warfarin o Dicumarol, on prothrombin time, thu indicating a decrease in the dosag requirements of the anticoagulants. O the other hand, dosage requirement of antidiabetic drugs have been reported to be increased during dextrothyroxine therapy (see WARNING section).

Dosage and Administration
For **adult** euthyroid hypercholestero emic patients, the recommended maintenance dose of CHOLOXIN (sodiu dextrothyroxine) is 4 to 8 mg per da The initial daily dose should be 1 to mg to be increased in 1 to 2 mg increments at intervals of not less than on month to a maximum level of 4 to mg daily, if that dosage level is ind cated to effect the desired lowering c serum cholesterol.

When used as partial or complete substitution therapy for levothyroxine i hypothyroid patients with cardiac disease who cannot tolerate other type of thyroid medication, the initial dail dose should be 1 mg to be increase in 1 mg increments at intervals of nc less than one month to a maximui level of 4 to 8 mg daily, preferably th lower dosage. The maximum in patient receiving digitalis therapy is 4 mg.

For **pediatric** hypercholesterolemic patients, the recommended maintenanc dose of CHOLOXIN is approximately 0. mg per kilogram. The initial daily do age should be approximately 0.05 m per kilogram to be increased in up t 0.05 mg per kilogram increments a monthly intervals. The recommende maximal dose is 4 mg daily, if tha dosage is indicated to effect the desired lowering of serum cholesterol.

If new signs or symptoms of cardia disease develop during the treatmen period, the drug should be withdraw

How Supplied
CHOLOXIN (sodium dextrothyroxine) supplied in prescription packages scored 1, 2, 4, and 6 mg tablets.

FLINT LABORATORIE
DIVISION OF TRAVENOL LABORATORIES INC
Deerfield, Illinois 60015

Preliminary Program
117th Annual Session

MISSOURI STATE MEDICAL ASSOCIATION

Chase-Park Plaza Hotel, St. Louis April 17-20, 1975

Thursday, April 17

11:00 AM Registration of Delegates.
1:30 PM House of Delegates Meeting, opening session.
3:00 PM Reference Committee Meetings.
6:30 PM Missouri State Surgical Society Executive Council Meeting.

Friday, April 18

8:00 AM Registration.
9:00 AM General Session. *National Health Insurance.*
Introduction: James C. Cope, M.D., Columbia, MSMA President.
Speaker: To be announced.
10:30 AM Intermission to view exhibits.
10:30 AM Presiding: Jean Chapman, M.D., Cape Girardeau, President, Missouri State Allergy Association.
Participants:
Opening Remarks, Jean Chapman, M.D.
Bronchial Asthma: A Pilot Model for Diseases with Multiple Causes, Max Samter, M.D., Chicago, Ill., Professor of Medicine, Abraham Lincoln School of Medicine and Director, Institute of Allergy and Clinical Immunology, Grant Hospital.
Determination of Saliva Theophylline Concentrations in Asthmatic Children, Stephen A. Leslie, M.D., Kansas City, Fellow in Allergy and Immunology, The Children's Mercy Hospital.
Immunotherapy in Malignant Disease, Larry E. Millikan, M.D., Columbia, Associate Professor of Dermatology, University of Missouri Medical Center.
"T" Cell Deficiency (Nezaloffs)—Case Report, Donald Strominger, M.D., St. Louis, Assistant Clinical Professor of Pediatrics, Washington University School of Medicine.
The Ecology of Ragweed Pollinosis, William Solomon, M.D., Ann Arbor, Mich., Associate Professor of Internal Medicine, University of Michigan Medical School.
Sponsored by the Missouri State Allergy Association.
*11:00 AM *Nuggets of Internal Medicine.*
Participants: To be announced.
Sponsored by the Missouri Society of Internal Medicine and the American College of Physicians (Missouri Region).
*11:00 AM *Common Problems in Infectious Diseases.*
Moderator: C. Terrence Dolan, M.D., North Kansas City.
Panel Discussants:
Martin C. McHenry, M.D., Cleveland, Ohio, Head, Department of Infectious Diseases, Cleveland Clinic.
C. Terrence Dolan, M.D., N. Kansas City, Department of Pathology, N. Kansas City Memorial Hospital.
Sponsored by the Missouri Society of Pathologists, Inc.
*11:00 AM *Intestinal Bypass for Morbid Obesity.*
Moderator: George L. Tucker, M.D., St. Louis.
Panel Participants:
Gene B. Starkloff, M.D., St. Louis.
Boyd E. Terry, M.D., Columbia.
Duane Q. Hagen, M.D., St. Louis.
Sponsored by the Missouri State Surgical Society.
*11:00 AM Program to Be Sponsored by the Missouri Thoracic Society.
12:30 PM Missouri University Alumni Luncheon.
12:30 PM Missouri Society of OB-GYN and American College of Obstetricians and Gynecologists Luncheon.
12:30 PM Missouri Thoracic Society Luncheon.
* 2:00 PM Participants:
Therapeutic Approach in the Resistant Asthmatic, Hyman Chai, M.D., Denver, Colo., Director of Hospital Services, The National Asthma Center.
Rast Inhibition for Determination of Antigen Standardization, Robert J. Dockhorn, M.D., Kansas City, Chief of the Allergy-Immunology Section, The Children's Mercy Hospital.

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* Concurrent Sessions.

Clinical Standardization of Allergenic Extracts, James W. Willoughby, M.D., Kansas City, Lecturer in Medicine, University of Missouri School of Medicine.
Phagocytic Function in an Atopic Population, Christopher Gifford, M.D., Kansas City, Fellow in Allergy and Immunology, The Children's Mercy Hospital.
Round Table Discussion: The Problem Allergic Patient, Max Samter, M.D., William Solomon, M.D., Hyman Chai, M.D.
Sponsored by the Missouri State Allergy Association.

° 2:00 PM *Symposium: Coronary Artery Disease—A Continuing Controversy.*
Moderator: To be announced.
Participants:
Can It Be Prevented?, Jerome D. Cohen, M.D., St. Louis, Chief, Department of Internal Medicine, St. Louis County Hospital.
The Aggressive Plan of Management, Ben McCallister, M.D., Kansas City, Associate Professor of Medicine, University of Missouri-Kansas City.
The Conservative Plan of Management, Richard Martin, M.D., Columbia, Professor of Medicine, University of Missouri-Columbia.
Sponsored by the Missouri Society of Internal Medicine and American College of Physicians (Missouri Region).

° 2:00 PM *Role of the Pediatric Nurse Practitioner in Care of Children,* Larry Kahn, M.D., St. Louis, Associate Professor, Department of Pediatrics, Washington University School of Medicine.
Panel Participants: To be announced.
Sponsored by the Missouri Chapter, American Academy of Pediatrics.

° 2:00 PM *Sexual Dysfunction,* Marcel Saghir, M.D., St. Louis.
Moderator: Richard T. Quick, M.D., St. Louis.
Sponsored by the Missouri Psychiatric Association.

° 2:00 PM *The Surgical Treatment of Breast Cancer.*
Moderator: John S. Spratt, Jr., M.D., Columbia.
Speaker: Robert Hermann, M.D., Cleveland, Ohio.
The Results of Selective, Conservative Treatment for Breast Cancer—A Ten-Year Follow-Up.
Panelist: Leslie Wise, M.D., St. Louis.
Sponsored by Missouri State Surgical Society.

3:30 PM **Intermission to view exhibits.**
4:00 PM **House of Delegates,** second session.
5:00 PM Missouri State Medical Foundation Annual Meeting.
6:00 PM **Reference Committee Meetings.**
6:00 PM Cocktails and Dinner: Missouri State Allergy Association.
6:00 PM Cocktails and Dinner: Missouri Psychiatric Association.
Speaker: Melvin Sabshin, M.D., Medical Director, American Psychiatric Association.
Problems and Prospects in Psychiatric Education.
6:30 PM Dinner Meeting: Missouri State Surgical Society.
Speaker: Vallee L. Willman, M.D.
Trends in Surgical Education: Graduate and Postgraduate.

Saturday, April 19

8:00 AM Registration.
° 9:00 AM *Nuggets of Internal Medicine.* Sponsored by the Missouri Society of Internal Medicine and the American College of Physicians (Missouri Region).

° 9:00 AM *High Risk Pregnancy.*
Moderator: James P. Crane, M.D., Lindenwold, N. J.
Participants:
Antepartum Management—An Organized Approach, James Crane, M.D., Lindenwold, N. J.
Sonography, Jacques Sauvage, M.D., St. Louis, Associate Professor, OB-GYN, Washington University.
Fetal Scalp Sampling, Timothy O'Connor, M.D., St. Louis, Instructor, OB-GYN, St. Louis University.
Amniocentesis and Evaluation of Fetal Maturity, Manuel R. Comas, M.D., St. Louis, Associate Professor, OB-GYN, St. Louis University.
Discussion, followed by Question and Answer Period.
Sponsored by the American College of Obstetricians and Gynecologists.

° 9:00 AM *Program on Ophthalmology.* Sponsored by the Missouri Ophthalmological Society, Inc.

° 9:00 AM *Medical Uses of Acupuncture,* Robert D. Baer, M.D., Salt Lake City, Utah, Holy Cross Hospital.
Bedsores, a Preventable Complication, Shirley M. McCleur, M.D., Columbia, University of Missouri.

° Concurrent Sessions.

Improvised Mechanical Devices for the Severely Handicapped Patient Confined to Bed or Wheelchair, Otakar Machek, M.D., St. Louis.
Moderator: Franz U. Steinberg, M.D., St. Louis.
Sponsored by Physical Medicine and Rehabilitation.

* 9:00 AM *Transplantation of the Kidney in Missouri.*
Moderator: William T. Newton, M.D., St. Louis.
Panelists: Gilbert Ross, Jr., M.D., Columbia.
Fred Whittier, M.D., Kansas City
Sponsored by the Missouri State Surgical Society.

10:30 AM **Intermission to view exhibits.**

*11:00 AM *Fiberoscopy in Diagnosis and Treatment of Cancer.*
Moderator: To be announced.
Panelists:
Rectosigmoid and Colon, Burton A. Shatz, M.D., St. Louis, Associate Professor of Medicine, Washington University School of Medicine, and Chief of Gastroenterology, Jewish Hospital of St. Louis.
Upper GI Tract and Appendages, Edward D. Kinsella, M.D., St. Louis, Clinical Associate Professor of Medicine, St. Louis University School of Medicine.
Bronchial Tract, Howard A. Andersen, M.D., Rochester, Minn., Department of Thoracic Diseases and Internal Medicine, Mayo Clinic.
Sponsored by the Missouri Division of the American Cancer Society.

*11:00 AM *Chronic Otitis Media.*
Moderator: Donald J. Joseph, M.D., Columbia.
Panel Discussants:
History and Physical Findings, Lindsay L. Pratt, M.D., St. Louis.
Radiological Findings, Joseph W. West, M.D., St. Louis.
Medical Therapy, Floyd R. Barnhill, M.D., Springfield.
Surgical Management, Michael F. Hughes, M.D., Kansas City.
Sponsored by the Missouri Ear, Nose and Throat Association, Inc.

*11:00 AM *Program on Neurology.* Sponsored by the St. Louis Neurological Sciences.

*11:00 AM *Ambulatory Gynecology—Newer Aspects.*
Moderator: William Ott, M.D., St. Louis
Participants:
Overview and Diagnostic Uses of Laparoscopy, William Ott, M.D., St. Louis, Instructor OB-GYN, St. Louis University.
Therapeutic Uses of Laparoscopy, Ernst Friedrich, Jr., M.D., St. Louis, Associate Professor, OB-GYN, Washington University.
Colposcopy, H. Marvin Camel, M.D., St. Louis, Associate Professor, OB-GYN, Washington University.
Endometrial Sampling, Praphat Hovadhanakul, M.D., St. Louis, Assistant Professor, OB-GYN, St. Louis University.
Discussion followed by Question and Answer Period.
Sponsored by the American College of Obstetricians and Gynecologists.

*11:00 AM *PSRO in Missouri, 1975.*
Moderator: Richard V. Bradley, M.D., St. Louis.
Panelists: To be announced.
Sponsored by the Missouri State Surgical Society.

12:30 PM **MSMA General Luncheon.**
12:30 PM **Fifty-Year Club Luncheon.**
12:30 PM Physical Medicine and Rehabilitation Luncheon.
12:30 PM St. Louis Neurological Sciences Luncheon.
12:30 PM Missouri State Society of Neurological Surgeons Luncheon.
12:30 PM Missouri Ophthalmological Society, Inc., Luncheon
1:30 PM *Program on Radiology.* Sponsored by the Missouri Radiological Society.

* 2:30 PM *Common Skin Diseases, Management Pearls.*
Moderator: Gordon C. Sauer, M.D., Kansas City.
Panel Participants:
Norman Asel, M.D., Columbia.
Donald Fuhrman, M.D., Kansas City.
James Sisk, M.D., St. Louis.
Wilfred Wooldridge, M.D., Springfield.
(Slides of Cases will be presented and the panel will make comments appropriate to management.)
Sponsored by the Missouri Dermatological Society.

* 2:30 PM Moderator: Ben D. McCallister, M.D., Kansas City.
Speakers:
Studies on the Objective Results of the Coronary Artery Bypass Surgery Graft Patency, Coronary Blood Flow, Survival—The Cardiologist's View, Robert Frye, M.D., Rochester, Minn., Chairman, Cardiovascular Diseases, Mayo Clinic.

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* Concurrent Sessions.

Studies on the Objective Results of Coronary Artery Bypass Surgery Graft Patency, Coronary Blood Flow, Survival—the Surgeon's View, Duncan A. Killen, M.D., Kansas City, Professor of Surgery, University of Missouri-Kansas City.
Sponsored by the Missouri Heart Association, Inc.
° 2:30 PM *Presentation of Papers by Junior Fellows of the American College of Obstetricians and Gynecologists.* (Authors of outstanding papers will be presented awards.)
Sponsored by the American College of Obstetricians and Gynecologists.
4:00 PM Intermission to view exhibits.
5:00 PM St. Louis University Medical Alumni Cocktail Party.
5:00 PM Washington University Medical Alumni Cocktail Party.
5:00 PM Missouri University Medical Alumni Cocktail Party.
6:30 PM Social Hour for Those Attending Banquet.
7:15 PM Annual Banquet in Honor of Past-Presidents.

Sunday, April 20

7:30 AM House of Delegates, breakfast and final session.

Continuing Education Coming Events

Feb. 12-14	**Symposium: Diagnostic Cytology** Postgraduate Education K.U. Medical Center, Kansas City, Kan.
Feb 26-28	**Seminar: Emergency Medicine** Danciger Institute for the Health Sciences Menorah Medical Center, Kansas City
March 7-8	**Missouri Regional Meeting,** American College of Physicians M.U. School of Medicine, Columbia
March 12-14	**Symposium: Pediatrics** Postgraduate Education K.U. Medical Center, Kansas City, Kan.

(Continued on page 87)

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The post-T & A patient:
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When the post-T & A patient requires an analgesic, a new problem arises. Hemorrhagic tendencies following the use of aspirin after tonsillectomies have been reported.[1,2] In a patient who "...has recently undergone a surgical procedure or has another underlying hemostatic defect, aspirin ingestion may cause significant bleeding.... Aspirin is absolutely contraindicated in such situations. Acetaminophen...could replace aspirin in these instances."[3]

The post-T & A patient is only one of several 'types for TYLENOL' antipyretic-analgesic products—that is, patients who should avoid aspirin. Considering *all* of them, wouldn't it provide added safety (as well as added convenience) to recommend TYLENOL products routinely for simple analgesia?

References: 1. Reuter, S.H., and Montgomery, W.W.: Arch. Otolaryng. *80*:214-217 (Aug.) 1964. **2.** Osol, A., et al., ed.: The United States Dispensatory and Physicians' Pharmacology, ed. 26, Philadelphia, J.B. Lippincott Co., 1967, p. 171. **3.** Schwartz, A.D., and Pearson, H.A.: J. Pediat. *78*:558-560 (March) 1971.

Precautions and Adverse Reactions: If a rare sensitivity reaction occurs, the drug should be stopped. Acetaminophen has rarely been found to produce any side effects.

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The Council Reports

Meeting of Dec. 14, 1974

Max S. Franklin, M.D., St. Louis, Chairman, called the meeting to order. Those present were Drs. Franklin; James C. Cope, Columbia; R. Allen Chandler, Kansas City; John I. Matthews, Jefferson City; Donald R. Judd, St. Louis; E. A. Stricker, St. James; John N. Martin, St. Joseph; Louis P. Hetlage, Troy; Robert E. Bregant, Jefferson City; William D. Bradshaw, Clinton; Andrew McCanse, Kansas City; Howard J. McAlhany, Springfield; Claude W. Cooper, Thayer; Eugene T. Hansbrough, Poplar Bluff; Stanley S. Peterson, Springfield; J. Loren Washburn, Versailles; Richardson K. Noback, Kansas City; George Thoma, St. Louis; Joseph White, William C. Allen and William D. Mayer, Columbia; Herbert R. Domke, Jefferson City; Charles Sherwin, St. Louis; Paul R. Young, Columbia; Mrs. George J. Lytton and Mrs. William R. McPhee, Kansas City; Messrs. James L. Hamilton and Timothy J. Danis, St. Louis; John F. Norwood and Robert Thebeau, St. Louis; Hollister S. Smith, St. Louis; Allen D. Smith, Kansas City; Ray McIntyre, Royal O. Cooper, C. C. Swarens, Ron Ellison and Don Wilson, Staff.

On motion, duly seconded, the minutes of the Sept. 14, 1974 Council Meeting were approved.

REPORT OF AD HOC COMMITTEE ON CME

Dr. Young stated that the Council had received a copy of the proposed *Accreditation Manual for Continuing Medical Education Activities in Missouri.* Dr. Young indicated that this program has been submitted to the AMA for approval. Basically, the program is a system which provides for accreditation for educational programs sponsored by hospitals, group practices, county medical societies, etc.

REPORT OF THE EXECUTIVE SECRETARY

Dr. Martin moved that the Council approve the continuing education program for implementation. Motion was seconded and carried.

Mr. McIntyre stated that at its December meeting, the AMA House of Delegates had approved a $60 assessment effective on Jan. 1, 1975 for all AMA members. This will be in addition to the current $110 AMA dues and will be billed directly to members from the AMA. This assessment is for one year. At its Annual Meeting in June in Atlantic City, the AMA House will consider whether or not to raise AMA dues.

Mr. McIntyre reported that the St. Louis Court of Appeals upheld the decision of the lower court in our favor in the suit against MSMA and the Health Care Foundation. The appellants have appealed to the St. Louis Court of Appeals for a rehearing or to the Supreme Court of Missouri. No decision has as yet been made in regard to the rehearing.

Mr. McIntyre stated that letters had been sent to the Commission and Committee Chairmen asking for their reports for the Handbook. Letters also have been sent to the presidents and secretaries of county societies asking for resolutions by the Speaker of the MSMA House of Delegates. Resolutions to be included in the Handbook should be in the MSMA office no later than March 1.

Mr. McIntyre reported that the MSMA Woman's Auxiliary is seeking tax exempt status. The charter for the Woman's Auxiliary will have to be expanded in certain objectives and specifications. Legal counsel is working on this matter.

REPORT OF BUDGET AND FINANCE COMMITTEE

The Budget and Finance Committee met on Friday afte noon, December 13, prior to the Council Meeting on Satu day. The Committee reviewed the material presented whi showed Exhibit A—Actual Income through Oct. 31, 197 Expected Total Income for 1974, Income Budget for 197 and Estimated Receipts for 1975. Exhibit B—Actual E penditures through Oct. 31, 1974, Estimated Expenditur for 1974, Budget for 1974 and Proposed Budget for 197 Exhibit C—Actual Meeting and Committee Expens through Oct. 31, 1974, Estimated Expenses for all of 197 Budget for 1974 and Proposed Budget for 1975. A brea down of anticipated income and expenses for the years 197 and 1975 also was included.

The Budget and Finance Committee approved the follo ing proposed budget for 1975:

Salaries	$169,198.00
Furniture and Fixtures	500.00
General Expense	4,550.00
Office Supplies	5,550.00
MSMF Assessment	41,000.00
Journal Expense	44,000.00
Postage	6,000.00
Equipment Rentals and Repairs	4,000.00
Telephone and Telegraph	8,600.00
Pension Expense	30,000.00
Legal and Professional	9,000.00
Payroll Taxes	8,655.00
Commission-Committee Meetings	51,800.00
Annual Session	23,000.00
Discretionary Council Fund	5,000.00
Taxes—I.R.S.	1,200.00
Travel Expenses	17,000.00
Building Expense	13,300.00
MMPAC Educational Projects	3,000.00
Improvements to Building	2,500.00
Total	$447,803.00

Dr. Judd, Chairman of the Budget Committee, report that it was felt that there is a need to hold down the penses of the AMA Delegates. Therefore, instead of payi all of the expenses for the AMA Delegates, the Budget Co mittee suggests to the Council that the AMA Delegates furnished with airfare and a reasonable per diem. Dr. Ju indicated that he and Mr. McIntyre would come up with suggested per diem. Motion was made, duly seconded a passed that the 1975 proposed Budget be approved.

1975 AMA CLINICAL SESSION

Mr. Cooper indicated that he had been in contact w Group Travel Unlimited in regard to group travel plans the 1975 AMA Clinical Meeting in Hawaii. He said t there will be two separate departures from Kansas City a two from St. Louis. He stated that these travel plans ne Council approval with additional details to be worked out.

It was moved by Dr. Hetlage to approve the travel pla for the 1975 AMA Clinical Meeting in Hawaii. Motion w seconded and carried.

REMARKS OF THE PRESIDENT

Dr. Cope stated that he had received a letter from member in Columbia suggesting that a collection be tak to help finance the way of the student delegates to the nnual Meeting. Dr. Cope indicated that he had suggested at this matter be run through the Boone County Medical ciety.

Dr. Cope said that the MSMA had been given the oppor- nity to appoint a representative of MSMA to the Board of e Health Care Foundation PSRO Support Center. Dr. em Grebel of St. Louis has been appointed as our repre- ntative.

Dr. Cope reported briefly on a number of medical meet- gs he had attended since the last Council Meeting includ- g Clinical AMA.

REPORTS OF DISTRICT COUNCILORS

District #1—Dr. Martin voiced his displeasure with some the changes currently taking place within the AMA.

District #3—Dr. Franklin reported that the installation officers of the St. Louis Medical Society will be held on nuary 7. Dr. August W. Geise, Jr. will be installed as Pres- ent and Dr. James Stokes will be installed as President- lect. Dr. Franklin extended an invitation to all present to tend this affair.

District #4—Dr. Hetlage stated that his district favored e certification of physician assistants and that this be done the State Board of Registration for the Healing Arts. The w should contain provisions regarding training and pro- de for some control of the physician using such an assist- nt.

The Fourth District expressed concern that the AMA was oposing to no longer seek advertising and recommends at the MSMA does not follow suit.

Dr. Hetlage stated that his district feels that the local SRO Foundation should make determinations on post ad- ission certification of Medicaid patients.

Dr. Hetlage said the Fourth Councilor District would like recommend to the AMA Delegation that they take oppo- tion to the SSA Regulation regarding certification within hours and scheduled to go into effect on Feb. 1, 1975. was pointed out that no one is ready to implement this gulation on February 1.

Motion was made, duly seconded and adopted that coun- medical societies, hospital associations and local PSRO roups be asked to communicate with HEW expressing op- osition to implementation of the regulation on February 1, nce none of the groups feel prepared at this time.

Dr. Hetlage indicated that CEMPROC is alive and well. e reported that the Fourth District felt that the Health are Foundation has gone off in a mistaken direction and attempting in some way to supercede MSMA as a central presentative organization. The Health Care Foundation proposing to offer various programs that are presently be- ng offered by MSMA.

Dr. Hetlage directed the Council's attention to the Buck- y Amendment. This amendment permits or demands the ivulgence of previously privileged information to the indi- idual concerned. He indicated that, possibly, a patient now ould demand access to his medical records. He stated that e would like for this to be referred to a Commission or ommittee for study.

Dr. Noback stated that it is UMKC's understanding that is applied only to Medical Schools.

Dr. Franklin indicated that this matter would be referred the Commission on Continuing Education and Health anpower for study.

Dr. Hetlage stated that the St. Louis County Health De- artment Drug Abuse Program is not utilizing M.D.'s in eir program.

He stated that this fall, St. Louis County had sponsored county medical society officers meeting and that all pres- nt at this meeting felt that it was valuable. He said that he would like the Council to authorize a yearly meeting of this nature at no expense to MSMA.

Dr. Hetlage indicated that it was felt that due to the discontinuance of the AMPAC Workshops held in Washington each year, that the MSMA should consider sending a delegation to Washington yearly for a political briefing and to contact our Congressional Delegation.

District #5—Dr. Bregant indicated that he had no report at this time.

District #6—Dr. Bradshaw stated that all is well in his district.

District #7—Dr. McCanse reported that the Jackson County Annual President's Dinner will be held on January 10 and everyone is invited.

Dr. Malcolm Todd, the President of the AMA, will be in Kansas City on January 28 and 29 to address the first graduating class of the Mid-America Regional Council, Emergency Rescue Paramedics. A special meeting of the Jackson County Medical Society will be held to honor Dr. Todd on January 28. Everyone is invited to attend this function.

Dr. McCanse stated that Dr. Don Blim is the new President-Elect of Jackson County Medical Society and that the new medical school in Kansas City was dedicated on October 27. Jackson County will be implementing a TEL-MED System, and a continuing education committee has been appointed. There is concern in Jackson County about the current malpractice situation and there also is concern about the confidentiality of medical audit committee reports. Dr. McCanse stated that there is currently a program being carried out by medical students that, perhaps, has some ethical considerations. The students go into physicians' offices and leave forms and brochures describing an emergency medical service card that can be obtained by patients. The students are receiving some profit from the sale of these cards.

District #8—Dr. McAlhany stated that he had no report at this time.

District #9—Dr. Cooper stated that he had no report at this time.

District #10—Dr. Hansbrough stated that people are upset with the AMA assessment and the manner in which it is to be handled. He indicated that perhaps we should inform the AMA of this.

Dr. Hansbrough indicated that there is concern in his area over the Hospital Discharge Data Program. The SEMO Foundation is conducting continuing education programs and will be applying for certifications of their continuing medical education programs under the MSMA's new program.

GROUP PROFESSIONAL LIABILITY INSURANCE

Mr. James Hamilton of Rollins Burdick Hunter outlined for the Council their continuing efforts to obtain underwriters for a professional liability insurance program in Missouri. There have been some problems in the market place for malpractice insurance. Mr. Hamilton stated that, at this time, the program for the MSMA is 45% complete. He indicated that he would like to obtain from the Council another 90 days to complete the program for Missouri. Mr. Hamilton reported that he had arranged with Hartford and Lloyd's of London to take applications for malpractice insurance from physicians who are having problems obtaining it. This is to be done until such time as the MSMA has a program ready for its members.

Motion was made, duly seconded and adopted to give Rollins Burdick Hunter another 90 days to complete a professional liability insurance program to be sponsored by MSMA.

REPORT OF COMMISSION ON PUBLIC AFFAIRS

The Commission on Public Affairs met on September 29 and submitted the following report to the Council.

The Commission voted against recommending a Public Affairs Conference for 1975. Despite excellent programs, attendance has been poor—mostly captive. As a replacement, the Commission recommends:

(A) Encourage physicians to appear before local clubs and organizations to tell medicine's story.

(B) Stimulate a Speaker's Bureau in areas in which they are not now functioning and have present Speaker's Bureau do more. Identify speakers who are capable and willing to serve.

(C) That the Association continue to sponsor specialized meetings which answer specific needs to members and prospective members—i.e., Management Workshops, Public Speaking Programs, etc.

The Commission also discussed the problem areas of physician distribution. It is hoped the various groups looking into this matter will concentrate more heavily on finding ways to stimulate self-sustaining groups to locate in rural areas rather than pinpoint individual physicians.

The following two motions were adopted by the Commission:

(1) "The MSMA should reevaluate the distribution of medical service in Missouri and reconsider the physicians' assistant's role in medical care."

(2) "The Commission feels that the MSMA should request all the medical schools in Missouri to consider assisting in alleviating the maldistribution of physicians training, by encouraging the preceptorship or similar programs and by investigating the possible advantages of expanded training for physician assistants."

In the area of communications, the Commission intends to delve further into the area of public information by telephone. We discussed the highly successful TEL-MED system, but felt that the high costs for a state-level operation would be prohibitive.

The Commission hopes that some of the larger component societies will research the possibility of gaining grant funds to operate TEL-MED or similar projects on a local basis.

The Commission discussed and rejected the possibility of publishing "tent cards" in Missouri Medicine. These cards would have been detachable and could be placed in physicians offices.

The Commission considered the Division of Health's concern regarding the present venereal disease outbreaks in the metropolitan areas and instructed staff to prepare an article for the Journal. Since the Division of Health expressed concern over the fact that physicians are not reporting cases of venereal disease, it was asked that the article stress that confidentiality will be safeguarded.

Dr. Allen Klippel presented an update on progress made in the field of emergency medical services since the passage of SB 57, *the Ambulance Bill*. Despite problems which are bound to arise in implementing any new legislation, it appears that SB 57 is serving to improve emergency medical care in Missouri by providing for better vehicles and expanded training for ambulance personnel.

The Commission enjoyed the presence and participation of Ed Burns, a medical student at the University of Missouri School of Medicine, during its meeting. Mr. Burns requested the Commission's endorsement of a grant study proposal to be submitted to HEW.

The study calls for development of evaluative criteria for emergency medical services in hospitals. Groups in various parts of the state will try to develop methods which they believe will provide for effective evaluation of hospitals in their area. A composite of these reports will then be molded into one report.

The overall purpose of the project is to provide guidelines whereby hospitals can more effectively set up their emergency medical service in cooperation and coordination with ot er hospitals in the area.

This project would be carried out by the Section of B havioral Sciences of the Department of Community Heal and Medical Practice at the University of Missouri-Colu bia Medical School.

Mr. Burns specifically requested the endorsement of t Commission and it was granted. The Commission reco mends that the Council also support this.

The two motions adopted by the Commission were d cussed and were accepted as information as there are va ous groups studying this problem.

Motion was made, duly seconded and adopted to acc the report of the Commission on Public Affairs.

REPORT OF THE MSMA FIELD SECRETARY

Mr. Don Wilson reported that in approximately t months of field work, he had made initial contact in all t districts. He stated that he had talked with officers a members in 32 of the 49 societies. He stated that physicia have been seemingly pleased and, in some cases, surpris that the State Association has someone to call upon them their offices. Talks with physicians have covered a wide va ety of subjects and matters of concern.

Dr. Hetlage expressed his approval and appreciation f what Mr. Wilson has done in his District and asked Mr. W son if he felt a second field secretary was necessary. M Wilson indicated that in some cases, he had only talked wi the President and Secretary of the Society, but had also tended a fair number of medical society meetings.

REPORT OF THE COMMITTEE ON CONSTITUTION AND BYLAWS

The Committee on Constitution and Bylaws met on N vember 25 and submitted the following recommendatio to the Council:

Recommendation #1—It is recommended that the MSM Council adopt their own mechanism to provide for someo to represent the Councilor District in the absence of t elected Councilor. The Committee recommends that if Council knows he will be unable to attend a meeting, may be allowed to designate a physician from his district represent him during the Council meeting. This designat representative could discuss and present the views of t Council District on all issues, but would not have the rig to vote. This designated representative could then meet a discuss the activities of the Council meeting with the Cou cilor.

Motion was made by Dr. McAlhany that Recommend tion #1 be accepted. Motion was duly seconded and ca ried.

Recommendation #2—If Resolution #40 providing f Unified Membership with the AMA is adopted at the fi session of the House of Delegates at the 1975 Annual Me ing, we suggest the following necessary changes in the Co stitution and Bylaws:

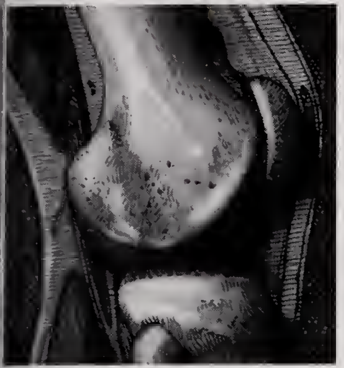
1. Amend the Constitution of the Missouri State Medic Association by striking out "Article III. Membership" a inserting in lieu thereof the following:

"Membership in this Association shall be limited to a include all members in good standing in component soci ties which hold charters from this Association and who a members in good standing of the American Medical Asso ation."

2. Amend the Bylaws of the Missouri State Medical A sociation as follows: Amend "Chapter I. Membership" striking out all of Section 1 of Chapter I and inserting lieu thereof the following:

(Continued on page 94)

IERE Muscles and joints



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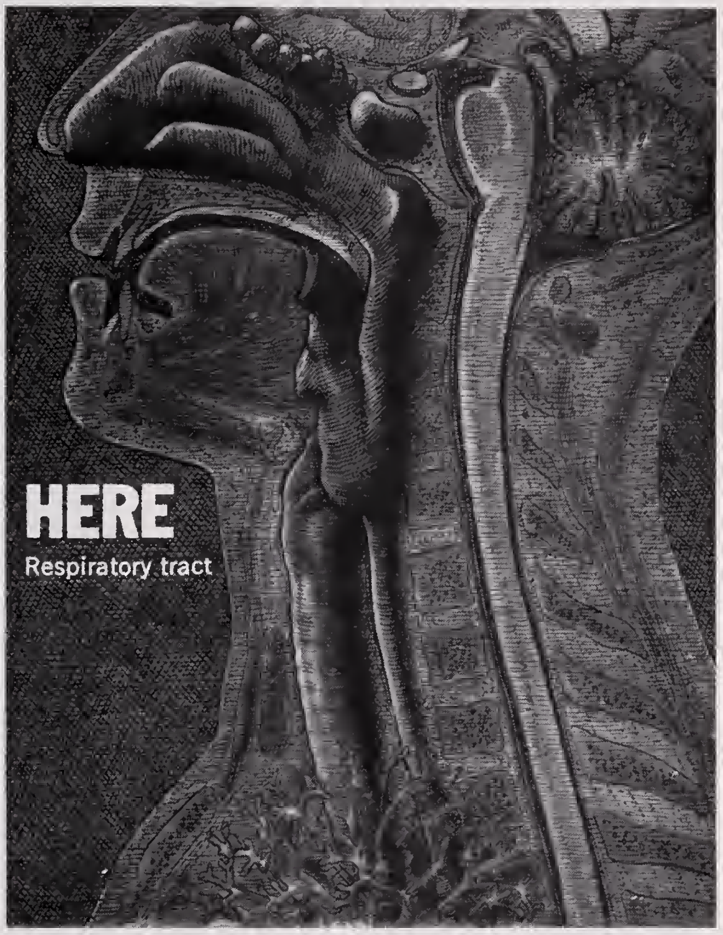

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The Role of the Detail Man

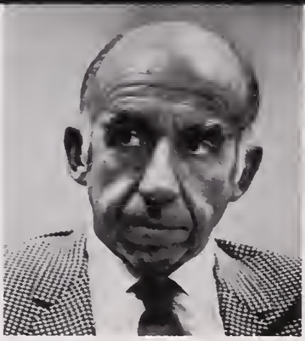
Opinion & Dialogue

Dr. Willard Gobbell
Family Physician
Encino, California

"I may be prejudiced, but I a very much in favor of the detail m I meet. Most of them are knowled able about the drugs they promot and can be a great help in acquai ing me with new medication."

Family Physician's Perception

I think that most general practitioners in this area feel as I do about the detail man. Over the years I have gotten to know most the men who visit me regularly ar they in turn have become aware my particular interests and the na ture of my practice. They, therefore, limit their discussion as muc as possible to the areas of interes to me. Since I usually see the sam representative again in future visits, it is in his best interest to supply me with the most honest, factual, as well as up-to-date information about his products.



Dr. Jeremiah Stamler
Chairman
Department of Community Health and Preventive Medicine, and Dingman Professor of Cardiology
Northwestern University Medical School

"In the total picture of dealir with health problems in this coun there is a potential for detail men to play a meaningful role."

The Positive Influence

My contact with representatives and salesmen of the pharmaceutical industry is the type of cor tact that people in a medical cente research people, and academic people have and that's in all likelih on a somewhat different level fron that of the practicing physician.

Let me touch on how I persor ally perceive the role of the sales representative. These men reach large numbers of health professionals. Thus they could be—and at times actually are—disseminators of useful information. They could consistently serve a real edu cational function in their ability to discuss their products.

At present they do distribute printed material, brochures and pamphlets—some of it scientifically sound and therefore truly useful—as well as some excellent film produced by the pharmaceutical industry. When they function in th

le a Source of Information?

Yes, with certain reservations. e average sales representative s a great fund of information out the drug products he is re- onsible for. He is usually able to swer most questions fully and elligently. He can also supply prints of articles that contain a eat deal of information. Here, , I exercise some caution. I usu- / accept most of the statements d opinions that I find in the pers and studies which come m the larger teaching facilities. oes without saying that a physi- n should also rely on other urces for his information on armacology.

aining of Sales Representatives

Ideally, a candidate for the sition as a sales representative a pharmaceutical company ould be a graduate pharmacist io has a questioning mind. I don't nk this is possible in every case, d so it becomes the responsibility of the pharmaceutical company to train these individuals comprehensively. It is of very great importance that the detail man's knowledge of the product he represents be constantly reviewed as well as updated. This phase of the sales representative's education should be a major responsibility of the medical department of the pharmaceutical company.

I am certain that most of these companies take special care to give their detail men a great deal of information about the products they produce—information about indications, contraindications, side effects and precautions. Yet, although most of the detail men are well informed, some, unfortunately, are not. It might be helpful if sales representatives were reassessed every few years to determine whether or not they are able to fulfill their important function. Incidentally, I feel the same way about periodic assessments of everyone in the health care field, whether they be general practitioners, surgeons or salesmen.

Value of Sampling

I personally am in favor of limited sampling. I do not use sampling in order to perform clinical testing of a drug. I feel that drug testing should rightly be left to the pharmacology researcher and to the large teaching institutions where such testing can be done in a controlled environment.

I do not use samples as a "starter dose" for my patients. I do, however, find samples of drugs to be of value in that they permit me to see what the particular medication looks like. I get to see the various forms of the particular medication at first hand, and if it is in a liquid form I take the time to taste it. In that way I am able to give my patients more complete information about the particular medications that I prescribe for them.

---

pacity they are indeed useful; rticularly in the fact that they sseminate broadly based educa- nal material and serve not just "pushers" of their drugs.

e Other Side of the Coin

Obviously, the pharmaceuti- l companies are not producing all is material as a labor of love— ey are in the business of selling oducts for profit. In this regard e ambitious and improperly moti- ted sales representative can ert a negative influence on the acticing physician, both by pre- nting a one-sided picture of his oduct, and by encouraging the actitioner to depend too heavily drugs for his total therapy. In ese ways, the salesman has often storted objective reality and ndermined his potential role as an ducator.

he Industry Responsibility

Since the detail man must be n information resource as well as representative of his particular harmaceutical company, he hould be carefully selected and thoroughly trained. That training, perforce, must be an ongoing one. There must be a continuing battle within and with the pharmaceutical industry for high quality not only in the selection and training of its sales representatives, but also in the development of all of its promotional and educational material.

The industry must be ready to accept constructive as well as corrective criticism from experts in the field and consumer spokesmen, and be willing to accept independent peer review. The better educated and prepared the salesman is, the more medically accurate his materials, the better off the pharmaceutical industry, health professionals and the public—*i.e.*, the patients—will be.

Physician Responsibility

The practicing physician is in constant need of up-dated information on therapeutics, including drugs. He should and does make use of drug information and answers to specific questions supplied by the pharmaceutical representative. However, that information must not be his main source of continuing education. The practitioner must keep up with what is current by making use of scientific journals, refresher courses, and information received at scientific meetings.

The practicing physician not only has the right, but has the responsibility to demand that the pharmaceutical company and its representatives supply a high level of valid and useful information. I feel certain that if such a high level is demanded by the physician as well as the public, this demand will be met by an alert and concerned pharmaceutical industry.

From my experience, my impression is that sectors of the pharmaceutical industry are indeed ethical. I challenge the industry as a whole to live up to that word in its finest sense.

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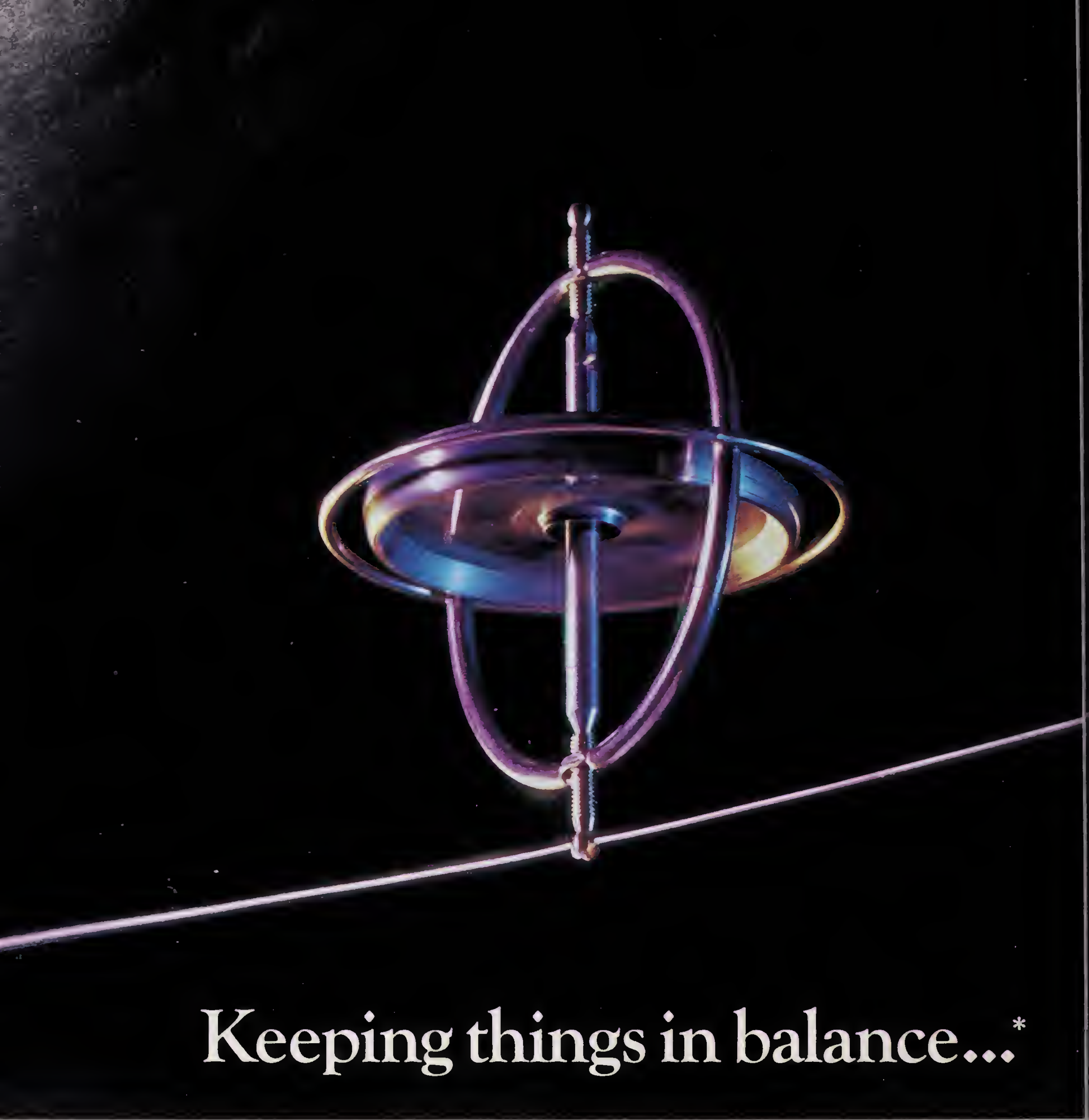

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Meclizine HCl is contraindicated in individuals who have shown a previo hypersensitivity to it.

WARNINGS. Since drowsiness may, on occasion, occur with use of this dru patients should be warned of this possibility and cautioned against driving a car operating dangerous machinery.

Usage in Children: Clinical studies establishing safety and effectiveness in childr have not been done; therefore, usage is not recommended in the pediatric age grou

Usage in Pregnancy: See "Contraindications."

ADVERSE REACTIONS. Drowsiness, dry mouth and, on rare occasions, blurred vision have been reported.

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WASHINGTON

The 93rd Congress concluded its two-year session hat was highlighted by the historic Watergate afair.

Congress held hearings but took no action on a ational Health Insurance (NHI) program. Howver, during the last days, the lawmakers approved health planning bill anticipating NHI. Earlier, hey voted for a liberalization of the Keogh plan llowing self-employed people to set aside much igher amounts for their retirement subject to tax eferral. Aid for medical education legislation founered and will be revived this year.

The Democratic victories in the November elecions, the Democratic push for legislative reforms ithin Congress and the downfall of Rep. Wilbur ills (D., Ark.) as Chairman of the House Ways nd Means Committee signalled a more liberal and ctivist Congress in 1975.

The House Democratic Caucus voted to pack Vays and Means, which has the prime jurisdiction ver NHI, with liberal Democrats and enlarge its nembership to 37, compared to 25 last year. The atio in 1975 is 25 Democrats, 12 Republicans. Rep. l Ullman (D., Ore.) is the new Chairman. For he first time, Ways and Means will be broken into ubcommittees. The Subcommittee on Health is eaded by Rep. Dan Rostenkowski (D., Ill.).

The Caucus stripped Committee Democrats of heir long-held power to appoint all House Democrats to committee slots, a move that weakened Vays and Means.

* * *

On the final day of the session in December, the ast Congress approved legislation giving health lanning agencies strong new authority over hosital services and construction. The lawmakers ailed to reach agreement on health manpower bills hat would have required many young physicians o serve in shortage areas and dictated apportionnent of specialization education at medical schools.

Both measures had stirred controversy and genrated opposition among health groups. The planing bill's most disputed original provisions would ave paved the way for public utility-type regulaion of physicians' services as well as those of institutions. These were dropped from the final verion sent to the White House.

The health manpower bill had been toned down from the one first backed by Sen. Edward Kennedy (D., Mass.) and approved by the Senate Labor and Public Welfare Committee. A more moderate substitute was adopted on the Senate floor minus such items as relicensing of physicians. However, medical schools and medical provider organizations, including the American Medical Association, had contended the scaled-down bill was still too harsh in its effect on young physicians and medical schools. This opposition plus Sen. Kennedy's decision to block action this year killed the health manpower legislation. Meantime, existing programs will continue as in the past.

The planning bill, approved by a 236-79 House vote a few weeks previously, was swiftly adopted by a House-Senate conference which ironed out differences in the bills approved by the two chambers. The compromise was adopted by the House and Senate only hours before the 93rd Congress quit.

Conceived as a preparatory measure to gear for a national health insurance program, the planning bill sets up an elaborate system of federal standards and regulations covering state and local health planning agencies and endowing them with strong power to force institutions to abide by planning decisions on services. All new hospital building and expansion would be subject to rigid controls.

The aim is to avoid waste and duplication, provide efficiency, raise quality and availability, and relieve shortage areas. The incentive for the states is federal aid. The ultimate impact of the bill will be increased control from the state and federal level on institutional health care.

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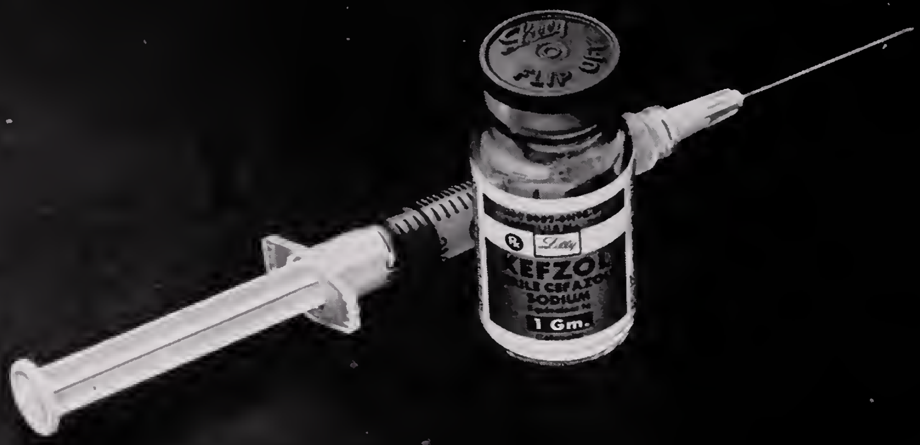
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Missouri Medicine

JOURNAL OF THE MISSOURI STATE MEDICAL ASSOCIATION

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BUFORD T. CASEBOLT, M.D., *Grand Forks, N. D.*

Use of Fabric Mesh in Abdominal Wall Defects

The basic principles of conventional hernia repair are well known. Unscarred fascia must be opposed with nonabsorbable sutures without excessive tension. Scarred fascia may be used as an aid to achieve overlap, but should not jeopardize the opposition of unscarred fascia. Most hernias can be repaired using these principles.

There are some hernias that cannot be repaired conventionally. To do so would violate the basic principles of hernia repair. Some of the problems nvolved in repair of difficult hernias are as follows:

In some recurrent hernias, little unscarred fascia remains. A conventional repair approximating scar-to-scar, while minimizing tension, is prone to recurrence. The excision of scar, followed by conventional repair, may result in excessive tension. Closure of a large fascial defect often places a severe strain on the repair irrespective of scar considerations. A few fascial defects cannot be closed at all. Fascial tension is not conducive to healing, produces postoperative morbidity and may result in recurrence.

Large incisional hernias of long duration, especially when chronically incarcerated, contain abdominal viscera which may have lost their right of domicile. When the contents of such hernias are reduced and the fascia are repaired under tension, postoperative pulmonary failure may occur, especially in elderly patients with impaired pulmonary reserve.

These problems led to the introduction of metallic meshes in the 1940s as an aid to repair of difficult hernias. The short-term results with metallic meshes were good. With longer follow-up, however, recurrences occurred due to work-fatigue fragmentation of the metal. Prosthetic fabric meshes, including polypropylene (Marlex) mesh and polyester (Mersilene) mesh, have surplanted their metallic predecessors. They are locally tolerated at least as well as metallic meshes and do not fragment, so that tensile strength is maintained indefinitely.

Fabric mesh, like its metallic forerunner, is a foreign material and predisposes the patient to infection—foreign body reaction in the wound. Because of this hazard, a few surgeons still avoid prosthetic meshes and, instead, use autogenous fascia, epidermis, relaxing incisions and other tissue-mobilization approximation techniques in difficult hernias.

In 35 cases in a nine-year experience, prosthetic fabric mesh was used for difficult incisional and inguinal hernias and in selected cases of wound dehiscence instead of retention sutures. The author analyzes the results and states that they are sufficiently favorable to warrant increasing use of fabric mesh in difficult hernias and abdominal wall problems. Dr. Casebolt was in the private practice of surgery in Kansas City at the time this paper was written. He is now practicing in Grand Forks, N. D.

TABLE 1

Type of Hernia		*No. of Cases*
Inguinal hernia		8
Incisional hernias		
Paracolostomy hernia	4	
Upper abdominal vertical incisional hernia	10	
Lower abdominal vertical midline incisional hernia	8	
Right upper quadrant and upper abdominal transverse incisional hernia	2	
	24	24
Dehiscence repair		2
Primary wound reinforcement instead of retention sutures		1
Total		35

TABLE 2

INDICATIONS FOR USE OF FABRIC MESH—
35 CASES

History of recurrences		
Inguinal (8 cases)	12	
Incisional (22 cases)	9	
	21	21
Wound tension factors (largely in incisional group)		
Fascia could not be approximated by any means	4	
Fascia could not be opposed with excessive tension	13	
	17	17
Obesity		15
Severe cough		11
Advanced pulmonary disease		6
Age over 80		4
Possible loss or right of domain (large hernias with chronic incarceration)		4
Arteriosclerotic heart disease with failure		2
Carcinomatosis		2
Heavy lifting as job requirement		2
Abdominal distention due to obstruction		2
Unusually large circular fascial defect		2
Poor quality fascia		2
Previous irradiation		1
Total		91

Beginning in the late 1950s, Usher[1] was the earliest advocate of prosthetic fabric mesh for difficult hernia repair. Reports of Usher's continuing experience[2-5] indicate enthusiasm and depict a number of new techniques.

Gibson[6] reported only one recurrence in his personal series of 25 incisional hernias repaired with fabric mesh reinforcement. Although Gibson[6] expressed concern about a 50% wound-complication rate, it was his conclusion that fabric mesh repairs should be offered to patients with hernias unrepa able by conventional techniques.

According to a nationwide survey by Adler[7] 1962, prosthetic mesh was used in 10% of all her orrhaphies. This report of widespread usage v derived from a nationwide survey of randon selected general surgeons throughout the U.S.A

Markgraf,[8] in November, 1972, reported th cases of combined wound dehiscence, peritoni abdominal distention and necrotic fascia in wh fabric mesh was used instead of retention sutu to reconstitute the abdominal wall. This was dc with fascial discontinuity and with the mesh posed by leaving the wound and skin open. T provided for intraabdominal and wound draina yet reconstituted the abdominal wall. Later, s ondary closure was performed and solved a di cult clinical problem in each case.

Data

This presentation reports a nine-year experier in the use of prosthetic meshes in selected abdor nal wall problems. There were 35 consecutive ca in 29 patients. There were eight inguinal herni 20 incisional hernias, four paracolostomy herni two dehiscence repairs and one instance of me usage in lieu of retention sutures (Table 1). T cases were selected because they represented di cult problems. Most hernias were repaired by cc ventional techniques and are not included in t series. All patients were personally operated on a followed. Marlex and Mersilene mesh were us approximately equally. The average age of patie was 65 years and was approximately the same each variety of hernia. There were 15 men a 20 women. All eight of the patients with ingui hernias were men.

Factors indicating the need for fabric mesh this series are listed in Table 2. A history of currence, wound tension, severe cough and obes were all common indications. Other less comm indications also are listed in Table 2. There was average of 2.6 indications for mesh employme per case.

In eight cases, additional major procedures we performed concomitantly on a planned basis. four additional cases, major problems encounter unexpectedly were corrected. Table 3 lists the additional potentially wound-contaminating cc comitant procedures.

Technique for Incisional Hernia

The cutaneous wound scar is excised ellipticа widely if there is an excess of skin and subcu- neous fat. The sac is usually opened. The ab- omen is usually explored.

Intraabdominal procedures can be performed ncomitantly on a planned basis. Intraabdominal oblems found unexpectedly should be corrected accessible.

An assessment should be made regarding the lvisability of mesh employment in the repair. actors relating to the patient's general status and oblems localized to the surgical area are con- dered.

If fabric mesh is to be used, unscarred fascia usually anterior rectus sheath) is exposed for a istance of 2 cm to 2½ cm beyond scar. Thinned arred fascia should be salvaged to avoid tension nd approximated or overlapped, providing its ood supply is adequate. Scarred fascia with poor ood supply should be excised. An obvious ad- ntage derived from salvaging scar is the addi- onal strength and peritoneal backing behind the nlay fabric mesh. If fascial approximation is im- ossible, inadvisable or might result in wound nsion, the defect should be bridged with pros- etic mesh. Sac peritoneum then should be sal- ged and approximated to prevent adhesions.

An onlay prosthesis of fabric mesh is then sewed the exposed, unscarred fascia peripherally with interrupted 2/0 nonabsorbable sutures. These e placed ¼ inch to ⅜ inch apart near the edges the implanted mesh. Occasionally, a second row sutures on each side and/or 0 caliber sutures e indicated where unusual postoperative stress is nticipated.

The mesh may reinforce an unscarred fascia-to- scia repair, bridge a scar-to-scar repair or even pan a fascial defect. Fig. 1 depicts the variations onlay fabric mesh repair used in this series. ypes 2A and 2B are variations of an onlay tech- ique but include the use of scarred fascia in the pair. Type 1 through Type 4 repairs differ in the creasing degree of fascial discontinuity resultant om an unclosable defect or from purposeful oidance of fascial tension or both. The legend r Fig. 1 also tabulates the number of cases of ch type in this series.

The wound is lavaged with saline solution and topical antibiotic (either dry powder or mini- ally dissolved with diluent) is spread about the pace created by mesh implantation. Closed suction rainage of the dead space using a large caliber ube should always be employed. A thick, fat layer ay require several tiers of closure.

Postoperatively, the suction drain tubes are removed when they cease functioning. The mesh implantation area is then periodically examined for seroma. Aspiration is the treatment of choice for seroma. The aspirate should be cultured to detect early infection of the mesh space.

TABLE 3

	Hernia Type	*Concomitant Procedures With Implanted Fabric Mesh*
Unplanned procedures—4 cases	Incisional hernia	Incidental appendectomy; adhesolysis
	Incisional hernia	Adhesolysis; segmental resection of ileum for denuded serosa
	Right inguinal incarcerated sliding hernia	Appendectomy for traumatic appendicitis; peri-appendicitis
	Incarcerated incisional hernia and intestinal obstruction	Obstructive resection; Mikulicz colostomy for colon carcinoma
Planned concomitant procedures—8 cases	Paracolostomy hernia	Left colectomy; colostomy closure; gastrectomy; vagotomy; hiatus hernia repair
	Paracolostomy hernia	Colostomy closure
	Paracolostomy hernia	Colostomy closure
	Paracolostomy hernia	Colostomy closure
	Incisional hernia	Panniculectomy
	Wound dehiscence with total fecal fistula	Take down of disrupted left colon anestomosis. Hartmann procedure
	Incisional hernia	Excision of cystic duct remnant; operative cholangiograms
	Incisional hernia; intestinal obstruction	Segmental resection of ileum and dome of bladder for carcinomatous recurrence producing small intestinal obstruction; complementary tube cystostomy

TECHNIQUE FOR WOUND DEHISCENCE

In two cases, fabric mesh was implanted for repair of wound dehiscence. In a third case, fabric mesh was used successfully instead of retention sutures to reinforce the wound closure in a high

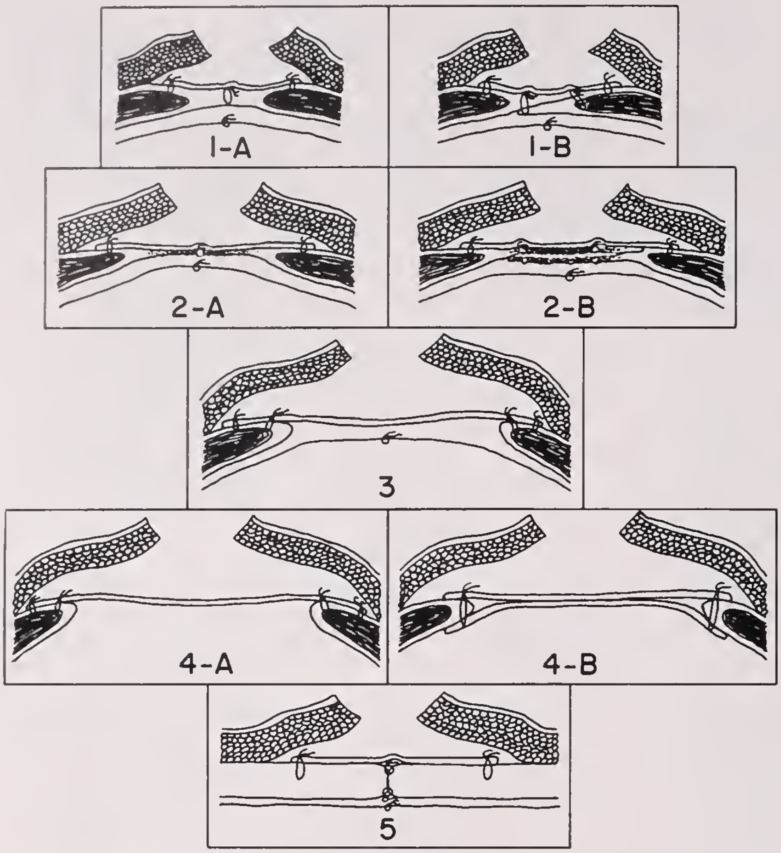

Fig. 1 Technical aspects of onlay fabr mesh usage showing variations in the exte of use of scarred and unscarred fascia a variations in the degree of fascial separati as follows: Type 1-A—6 cases—Unscarred f cia-to-fascia repair with onlay fabric mesh r inforcement. Type 1-B—2 cases—Unscarr fascia-to-fascia overlap repair with onlay fab mesh reinforcement. Type 2-A—10 cases—Sc to-scar repair with onlay fabric mesh rainfor ment. (Some fascial discontinuity with int posed scar.) Type 2-B—4 cases—Scar-to-sc repair with scar overlapped with onlay fab mesh reinforcement. (Some fascial discon nuity with interposed scar.) Type 3—7 cases Repair with complete fascial separation wi onlay fabric mesh spanning fascial defe (Peritoneum closed.) Type 4-A—2 cases—F pair with complete fascial separation to greater extent than on Type 3, with no pe toneal closure. Type 4-B—1 case—Same as 4 except double layer of fabric mesh (one ov lay, one underlay). Type 5—3 cases—Deh cence repair or reinforcement of ordina wound closure with onlay fabric mesh.

dehiscence-risk situation. The technique used in these three cases is depicted in Fig. 1, Type 5. The two dehiscence cases are worthy of individual review, since use of mesh for this purpose represents a new concept in surgical management.

An 80-year-old man developed a total fecal fistula through a dehiscence of a lower abdominal midline incision. Ten days previously, as an emergency and under adverse circumstances, a sigmoid colon resection with end-to-end anastomosis had been performed. The disrupted anastomosis was taken down and a Hartmann procedure fashioned. The peritoneum and fascia were reclosed and fabric mesh was used for reinforcement of the dehiscence closure. The grossly-contaminated wound was packed open with Furacin packing, leaving mesh exposed in the depth of the wound. In 30 days, the fabric mesh was removed. In ten additional days, a secondary closure of skin and fat was accomplished. No hernia has developed in the ensuing 19 months of follow-up.

The second case was that of a 40-year-old, obese woman with severe obstructive pulmonary disease, chronic severe cough and asthma. She developed a dehiscence in her upper abdominal midline incision in spite of prophylactically-placed retention sutures. The dehisced wound was reclosed and r inforced with prosthetic mesh instead of using r tention sutures again. An infected mesh spa seroma developed later. However, it was manag successfully. The mesh did not require removal ar no hernia developed.

Techniques for Inguinal Hernia

In the inguinal hernia group, seven patients ha tissue repairs reinforced with onlay mesh prosthes comparable to Type IA and Type IIA repairs (Fi 1). In one case, the mesh and transversalis fasc together were sutured to Cooper's ligament for recurrent direct inguinal hernia (a combination onlay and underlay techniques). Suction draina was not generally used in the inguinal hernia cas unless indicated for drainage of a large space.

Results

There were no mortalities. Pulmonary complic tions were almost nonexistent. There was one i stance of halothane hepatitis which responded supportive treatment including large doses of pre nisone. There were no complications of ileus thromboembolism.

There were two recurrences (6%) in 33 case oth recurrences were rerepaired using prosthetic esh again to bring the series to a total of 35 cases. o further recurrence has developed in the two ases rerepaired. Follow-up ranged from a few onths to nine years with a mean of 36 months. ollow-up was complete by way of current inquiry r examination except for one patient who could ot be located.

The first recurrence was found to be due to failre of sutures to hold the mesh at rerepair. This ccurred at the inferio-medial (recto-pubic) angle an inguinal hernia repair.

The second recurrence was in a case of a preious Type III repair (Fig. 1) of a lower abdomial incisional hernia. The mesh was previously used bridge a fascial defect. At rerepair, the recurnce was due to mesh failure with the new hernia manating through previously implanted mesh.

There were five minor wound complications 14%). There were three seromas which responded aspiration. One hematoma required surgical vacuation. One severe superficial stitch reaction ith cellulitis responded to antibiotics and suture moval.

Three serious deep wound infections occurred 8%). These involved the fabric mesh space and eserve special review.

Two of these appeared as infected seromas durg the first two weeks after mesh repair. Treatent of both cases consisted of insertion of a large aliber tube into the infected mesh space cavity on n inhospital basis. The cavity was measured voluetrically. For the next four to five days, the incted seroma space was subtotally filled with akins solution three times daily. The solution was llowed to remain in contact with the mesh for everal hours at each infusion. Thereafter, continuus suction was applied to the tube for several dditional days until serous drainage ceased. The ıbe was then removed. The seroma did not recur nd no further infection developed in either case.

The third deep mesh infection appeared initially s a coagulase positive Staphylococcus wound abcess. Later, in succeeding months, additional abcesses and sinus tracts developed. These were treatd initially and subsequently by incision drainage nd antibiotics. When the wound was explored nine onths later for persistant sinus tracts, less than 1% f the mesh was unenveloped and required removal long with a granulation-tissue-lined chronic abscess avity and sinus tracts. No further infection ocurred and no hernia recurrence developed.

Two of the three deep mesh infections occurred the 12 cases in which additional major wound contaminating procedures were performed. The third deep mesh infection developed in a case of dehiscence repair with mesh when contamination attendant on reoperation for dehiscence may have introduced infection.

Early in the series, suction drainage of the mesh space was employed to prevent infection. More recently and currently, topical intraoperative antibiotics also are used almost routinely to protect against infection.

Belzer *et al*[9] used intraoperative bacitracin and neomycin topically in the wounds of 354 renal transplant patients over a 4½-year period of study. These immunosuppressed patients are markedly predisposed to wound infection. Belzer's controlled study[9] demonstrated a significantly lower incidence of wound infection in the treated group.

COMMENTS

To fully appreciate the benign postoperative course of patients with fabric mesh repair of large incisional hernias, one has to have practiced in the era before prosthetic meshes were available. Repair of large incisional hernia defects were, of necessity, made under tension. Postoperative pain was marked and interferred with coughing. Atelectasis and pneumonitis were common. Air swallowing and postoperative abdominal distention were common. Nasogastric decompression was often required to prevent or treat abdominal distention. The right of domicile was sometimes infringed upon with mortality. Acute pulmonary failure could occur in the immediate postoperative period or in succeeding days as abdominal distention progressed. Recurrence was not uncommon since scar was often utilized in the repair. The advent of prosthetic fabric meshes has largely eliminated these problems by permitting varying degrees of fascial discontinuity and allowing repair without fascial tension. Repair of hernias previously considered not repairable can now be performed safely and with a higher degree of success.

The limited experience of using fabric mesh instead of retention sutures in selected cases of wound dehiscence and in a selected patient with predilection to wound dehiscence, as presented in this paper, indicates that such usage may occasionally be indicated. A much stronger wound closure can be obtained with fabric mesh reinforcement rather than adding retention sutures in a patient predisposed to dehiscence. A septic wound dehiscence, especially with intraabdominal sepsis, requires drainage as well as reconstitution of the abdominal wall. Both can be achieved by using several different techniques with the aid of fabric mesh.

It should be emphasized that prosthetic meshes should be reserved for the more formidable hernia and abdominal wall problem. Simple hernias should be repaired by conventional techniques. The 8% deep mesh space infection rate, plus a 14% minor wound complication rate in this series, should emphasize that prosthetic mesh should not be implanted indiscriminately.

Mesh-space wound infection remains a serious threat, but it is largely preventable with good technique, suction drainage and intraoperative topical antibiotics. Mesh space infection, when diagnosed early as an infected seroma, responds to closed perfusion of the mesh space with antiseptic solution with resultant sterilization of the infected space.

It is my personal conviction, based on increasing usage of fabric mesh over a nine-year period, that indications for mesh usage should be extended and fabric mesh should be used more frequently. This belief is based on the data and results presented herein and upon the belief that wound complications can be increasingly prevented. Probably, the most important consideration is the high degree of success in achieving a lasting hernia repair in difficult hernias. The 6% recurrence rate in this series is particularly respectable since mesh was used only for the difficult hernia.

Summary

1. Thirty-five consecutive cases of fabric mesh implantation in difficult abdominal wall problems are reviewed. The patients were operated on and followed personally.

2. The technical aspects of hernia repair with fabric mesh are presented. The use of mesh as a means to avoid fascial tension is stressed.

3. There were no mortalities.

4. There were two recurrences (6%) which were repaired with a fabric mesh with no further recurrence. The mean follow-up time in the series was 36 months.

5. Twelve of the 35 cases had various addition concomitant procedures, adding a potential sour of infection. Although two of the three deep-me space infections occurred in this group, mesh usa is compatible with concomitant contaminating i traabdominal procedures.

6. Minor wound complications (14%) include three uninfected seromas, one hematoma and o superficial stitch infection. All of these responde to standard treatment.

7. There were three additional serious dee wound infections (8%) involving the implante mesh. All three were aggressively and successful treated.

8. A prophylactic, intraoperative topical antib otic is recommended, especially if the wound contaminated.

9. A method of sterilization of infected me space seromas by closed perfusion instillation Dakin's solution was employed successfully in tw cases, and is recommended.

10. The use of fabric mesh to repair complicate acute wound dehiscence instead of retention s tures is suggested selectively.

11. The results are favorable enough to indica increasing fabric mesh usage in difficult abdomin wall problems.

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J. REGAN THOMAS, M.D. *and* **WILLIAM E. DAVIS, M.D.,** *Columbia*

Breast Carcinoma Metastatic to the Temporal Bone

ACUTE MASTOIDITIS, a relatively common entity until the advent of antibiotics, is now infrequent. Acute mastoiditis associated with malignant tumor invasion of the temporal bone has always been a rare phenomenon. The following case is of interest from this standpoint.

Furstenberg (1924) stated the incidence of primary carcinoma of the temporal bone to be one in 20,000 cases of patients presenting with ear disease.[1] Bezold (1907) had an incidence of one in 5,000 otology patients.[2] Secondary tumors to this area have been reported so rarely that the accurate incidence has not been defined. Schuknecht (1968) reviewed the world literature reporting metastatic tumors to the temporal bone and identified only 63 cases to which he added ten cases from his own series.[3] This case represents the 18th report of metastatic breast carcinoma to the temporal bone in the world literature.

CASE REPORT

The patient, a 49-year-old white woman, had undergone a right radical mastectomy five years prior to this admission. Two years later, she had sustained a pathologic fracture of the right hip which was treated by irradiation and pinning. She had been without further symptoms over the following year until she developed intermittent tinnitus and pain with a mild hearing loss in the left ear. One month after the onset of these symptoms, she was seen in the ENT Clinic and was found to have a pulsatile left serous otitis media and a conductive hearing loss of 20 dB. A diagnostic myringotomy was performed and clear fluid was removed from the middle ear with return of hearing to normal and cessation of pain. A Teflon ventilating tube was inserted into the tympanic membrane at this time. One week later, pain recurred and was accompanied by purulent otorrhea and tenderness over the mastoid. Cultures grew *Staph. aureus.* Acute mastoiditis was diagnosed, and forty-eight hours following treatment with large doses of intravenous Keflin, the patient became asymptomatic. The patient was discharged. She returned one week later with recurrence of severe mastoid pain, purulent discharge and a temperature of 103 F. Examination at this time revealed copious amounts of purulent drainage through the ventilating tube. Minimal pressure over the mastoid area caused severe pain. Audiometric examination showed a 20 dB air-bone gap in the left ear. The nasopharyngeal examination was normal. Well-healed right mastectomy and right hip scars were present. No adenopathy was noted. The liver edge was firm and palpable four fingerbreaths below the costal margin. Radiologic examinations revealed evidence of osteolytic metastases in the skull, cervical vertebrae, ribs, pelvis and left humerus. Mastoid films showed cloudiness of the left mastoid air cells.

After six days of intravenous Keflin treatment, the patient was taken to the operating room where a simple mastoidectomy was performed. The mastoid air cells were filled with granulation tissue. A large mass was encountered in the mastoid antrum which almost occluded the aditus. The tympanic cavity was filled with what appeared to be granulation tissue. The ossicles were intact. Pathology examination of the antral mass (Fig. 1) shows metastatic carcinoma surrounded by connective tissue and evidence of bone destruction.

The immediate postoperative course was uncomplicated and the patient was discharged on the fifth postoperative day. She died two months later of brain and visceral metastasis.

COMMENT

Metastasis to bone is a prominent feature of advanced breast, prostate, thyroid and renal carcinoma. As the incidence of breast carcinoma is so great, one would surmise that metastasis to the temporal bone would not be unusual.[4] As one reviews the literature, however, it becomes evident that this is not the case. It is probable, however, that metastasis is more common than the literature reflects because the symptoms may be overshadowed by the primary tumor or by metastasis to other organ systems. In most autopsy examinations, the temporal bones are not sectioned and only gross metastases

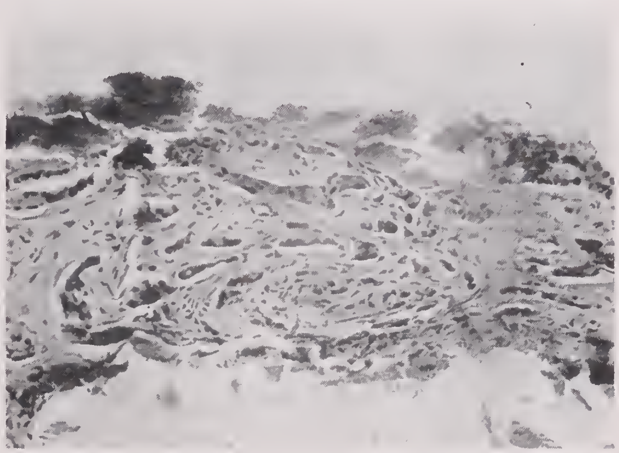

Fig. 1 Tissue removed from antrum shows carcinoma in connective tissue with several bone spicules being destroyed.

Primary or metastatic tumors of the temporal bone are relatively infrequent and only small series of cases have been reported. This is a case report of carcinoma of the breast which metastasized to the temporal bone and resulted in acute mastoiditis. The authors also review the literature. Drs. Thomas and Davis are from the Department of Surgery, Section of Otolaryngology, University of Missouri Medical Center.

are noted. It is likely that microscopic metastases to the temporal bone are common, but that they are only rarely diagnosed.

Marx (1926) suggests that metastasis to the temporal bone occurs in two ways. One route is by "otitis media interna carcinomatosa," which is essentially metastasis via the cerebrospinal fluid (CSF) and explained finding the canals of the cochlea filled with anaplastic cells and eroded by tumor while the remainder of the temporal bone is near normal and the tympanic membrane intact. The second route is by hematogenous spread and localizes in the marrow of squamous, petrosa and mastoid tip. Mastoiditis is then secondarily developed as the metastasis involves the air cells. Perhaps, it is because the marrow of the temporal bone changes from a vascular red marrow to a fatty yellow marrow in adults that more tumors do not metastasize to this area in the older age groups.[5, 6] Another factor which could decrease the number of potential metastases is that well-pneumatized bone offers very little marrow to filter out the tumor cells.

In the metastatic lesions, it should be noted that the primary tumor may be occult. Maddox (1967) reported that all four patients is his series first sought treatment for the metastatic lesion.[7] In adults with metastatic tumors, the most common primary lesions are breast, kidney and lung in origin, followed by stomach, larynx, prostate and thyroid. The metastatic symptomatology will vary depending on the area of involvement, but the majority present with conductive hearing loss, mastoiditis, subperiosteal abscess and facial paralysis. The tympanic membrane may or may not be intact. Radiologic examination may reveal either an osteoblastic lesion or an osteolytic lesion. All metastatic lesions are initially osteolytic, but breast and prostate neoplasms may become osteoblastic at a later date. There may be clouding of the mastoid cells on x-ray. When adenocarcinoma is found on biopsy, an extensive search for the primary must be made. Included in this workup would be careful breast and pelvic examination, chest x-ray and possible tomograms, upper and lower gastrointestinal (GI) series, intravenous pyelogram (IVP), liver profile and thyroid scan.[8]

The absolute diagnosis of these metastatic lesions depends upon histologic diagnosis. Our case represents a good example of the typical findings in these cases (Fig. 1). While the original tumor may be well differentiated, the metastatic lesion in general is less well differentiated and probably more aggressive in behavior. Prognosis of these tumors is indeed poor, but there is palliation with surgery and radiation therapy in some.

Acknowledgement: The author wishes to express appreciation to C. H. Jung, M.D. for making the photomicrograph available.

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R. C. WRAY, M.D. *and* **P. M. WEEKS, M.D.,** *St. Louis*

Management of Metacarpal Shaft Fractures

FREQUENTLY, THE PHYSICIAN is confronted with apparently simple fractures in the hand which can result in marked functional loss. This article presents a discussion of management of metacarpal shaft fractures.

In general, shaft fractures are either transverse, spiral or comminuted with or without disruption of the overlying skin. Initial examination includes a complete history of the circumstances of injury, inspection of the injured part and obtaining roentgenograms. With this information, a plan of therapy is devised. The necessity for hospitalization is resolved as the plan of therapy evolves.

The immediate objectives in treating shaft fractures include (1) reduction (either open or closed) and immobilization of the fracture (either by internal or external fixation) and (2) maintenance of digital length and proper rotation. Postoperative care is of equal importance and is directed toward preserving joint motion and minimizing adhesion formation to gliding structures, e.g. tendons, and edema formation.

Closed reduction usually can be obtained. However, if soft tissue becomes interposed in the fracture site preventing anatomical reduction, open reduction is required. Immobilization can be accomplished with either external or internal splinting. External splinting requires immobilization of at least two joints on either side of the fracture site and, frequently, more. Consequently, stiff joints and extensive adhesions to tendons are more liable to develop. Utilization of internal fixation can provide firm approximation and immobilization of the fracture. It also prevents rotatory movement of the finger, maintains digital length and allows early mobilization of the digital joints. Unfortunately, operative manipulation evokes further tissue reaction and introduces the additional threat of infection and the possible impalement of tendinous structures by the internal fixation devices.

Comminuted or spiral fractures predispose to "telescoping" and subsequent loss in length. Rotational deformity is common with any type fracture. To maintain digital length, the proximal pull of the intrinsic and extrinsic muscles of the hand must be counteracted by either internal fixation or external traction. When utilizing internal fixation, manual traction is applied to the finger and the distal segment of metacarpal fixed to stable adjacent metacarpals by transversing Kirschner wires.

Traction is difficult to apply and maintain. Skin traction presents the ever-present danger of constriction. Skeletal traction through a transverse wire piercing the phalanges provides firm attachment. Yet, the phalanges are basically covered by tendons on the volar, lateral and dorsal surfaces and render the uncovered areas for impalement of the phalanges insignificant. Consequently, any transverse wire impaling the proximal or middle phalanges will result in impalement of the extensor apparatus. A third method of traction is the use of pulp traction. This is used extensively and has been found to be very effective. Criticism has included the risk of infection, injury to nerves and vessels of the pulp and the development of pressure necrosis. The risk of these complications has made this a less than totally satisfactory method of applying traction.

Moberg has modified nail traction and suggested placement of a wire vertically through the fingertip, the periosteum of the distal phalanx and the nail.[1] This method is easy to perform and entails minimal risk of infection. Necrosis from pressure is prevented by utilizing a wire spreader. This spreading device prevents the wire from pressing on the intervening fingertip.

The following metacarpal fractures are more frequently unstable and require open reduction and internal fixation: (1) oblique fractures crossing more than one metacarpal shaft, (2) fractures through either the index or little finger metacarpals, (3) comminuted fractures and (4) fractures in which bony segments are lost.

Fractures of the thumb metacarpal will be discussed separately from those of the finger metacarpals.

Metacarpal shaft fractures may result in marked functional loss in the hand even though they may appear to be simple fractures. The authors discuss management of these fractures with which the physician is frequently confronted. Dr. Wray and Dr. Weeks are from the Hand Rehabilitation Center, Division of Plastic Surgery, Washington University School of Medicine.

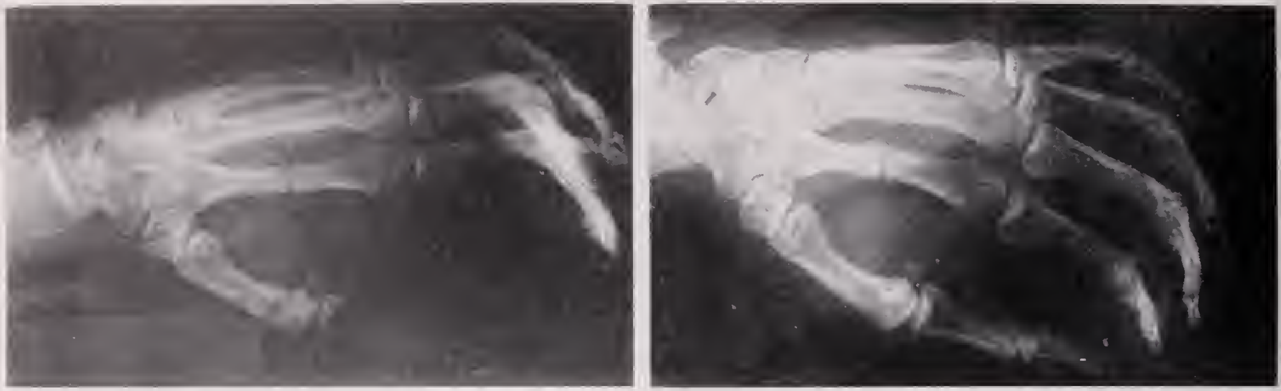

Fig. 1 *(Left)* Transverse fractures through the mid shaft of the index, long and ring metacarpals are evident. *(Right)* Note callus three weeks after mobilization in short arm cast.

FINGER METACARPAL FRACTURES

Transverse Fractures

Usually, a transverse fracture of the metacarpal shaft results in angulation at the fracture site, producing volar displacement of the metacarpal head. This angulation is accentuated by the pull of the intrinsic and long flexor muscles on the base of the proximal phalanx. Treatment of these fractures in the index and the little fingers can be more difficult than in the long and ring fingers because of the greater mobility and lateral position of the index and little fingers.

To obtain reduction, the proximal phalanx is grasped and the metacarpophalangeal joint flexed 90 degrees to produce tightening of the collateral ligaments about the metacarpal head. By this manuever, one gains control of the distal fragment. By gentle dorsal pressure, the metacarpal head is directed dorsally while the metacarpal shaft proximal to the fracture is forced volarward. (Digital malrotation is corrected by flexing the adjacent fingers with the fractured finger.) A short arm cast is applied. The metacarpophalangeal joint is flexed 70 to 80 degrees during the three weeks of immobilization. Stability at the fracture site is determined clinically by gentle pressure on metacarpal head. Exercises are begun as soon as the fracture site is stable (Fig. 1).

OBLIQUE FRACTURES

Oblique fractures have a marked tendency toward telescoping because of the proximal pull of the intrinsic muscles. This instability frequently promotes a rotational deformity of the distal segment. The effect of slight malrotation at the fracture site is deceptively great. If malrotation of 5 degrees is accepted in the midshaft of the metacarpal, the distal phalanx will exhibit 15 mm of overriding.[2] When there is telescoping of the fragments, length may be maintained by gentle closed reduction of the fracture and cross pinning to the adjacent stable metacarpal (Fig. 2). A second wire in the distal fragment is needed to prevent move-

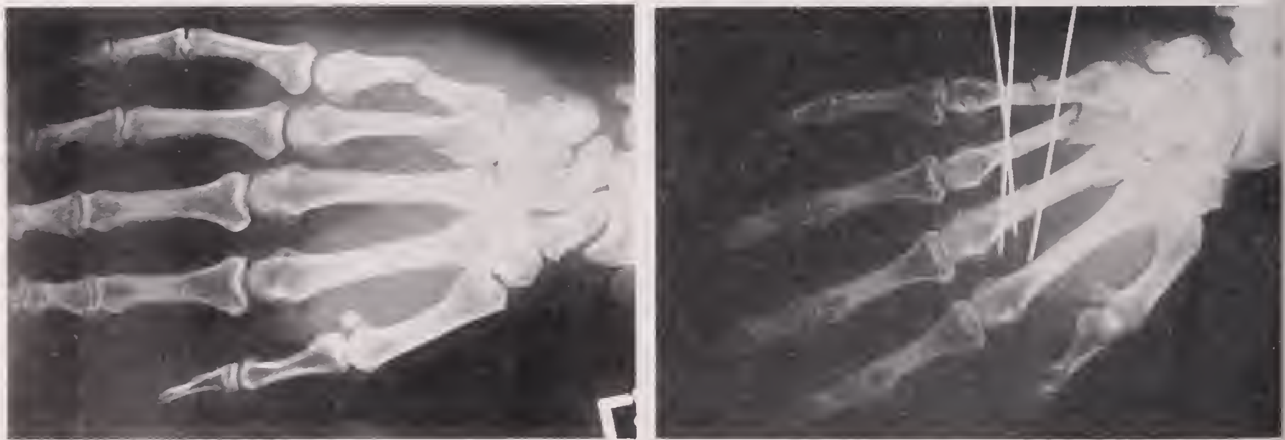

Fig. 2 *(Left)* Oblique fracture of the ring metacarpal and transverse fracture of the little finger metacarpal are difficult to maintain in a reduced state by casting. *(Right)* Transverse Kirschner wires are driven through the fractured metacarpals into the stable long finger metacarpal. Digital length and proper rotation are maintained. Mobilization of the fingers can begin immediately.

ment at the fracture site if exercises are begun early.

Comminuted Fractures

Comminuted fractures usually result from low velocity, weapon injuries or from crushing and require internal fixation to maintain length and proper rotation (Fig. 3). Fractures of the index and little finger metacarpals are more difficult to treat than are those of the long and ring metacarpals because the latter are splinted by intact metacarpals on either side. Comminuted fractures require internal fixation to prevent shortening of the digit and malrotation.

Thumb Metacarpal Fractures

The principles of treatment presented previously are applicable to fractures of the thumb metacarpal. Yet, the thumb is so important in hand function that particular care must be exercised to ensure proper reduction, alignment and immobilization. The plane of metacarpal rotation across the palm must be fully appreciated when positioning the thumb after fracture reduction. Fractures through the base or shaft are displaced by the tendinous structures inserting into each fragment (Fig. 4). The distal metacarpal fragment is flexed into the palm by the pull of the thenar muscles. The abductor pollicis longus inserts into the base of the thumb metacarpal. Its pull produces extension-abduetion of the proximal fragment. Since extension of the proximal fragment is limited by the ulnar ligament connecting the trapezium to the beak of the thumb metacarpal, the distal fragment should be manipulated to effect and maintain reduction. A transverse fracture can be adequately treated by closed reduction and application of a cast. It is important that angulation at the fracture site be prevented by either pressure applied by the cast or through external traction (Fig. 4-A).

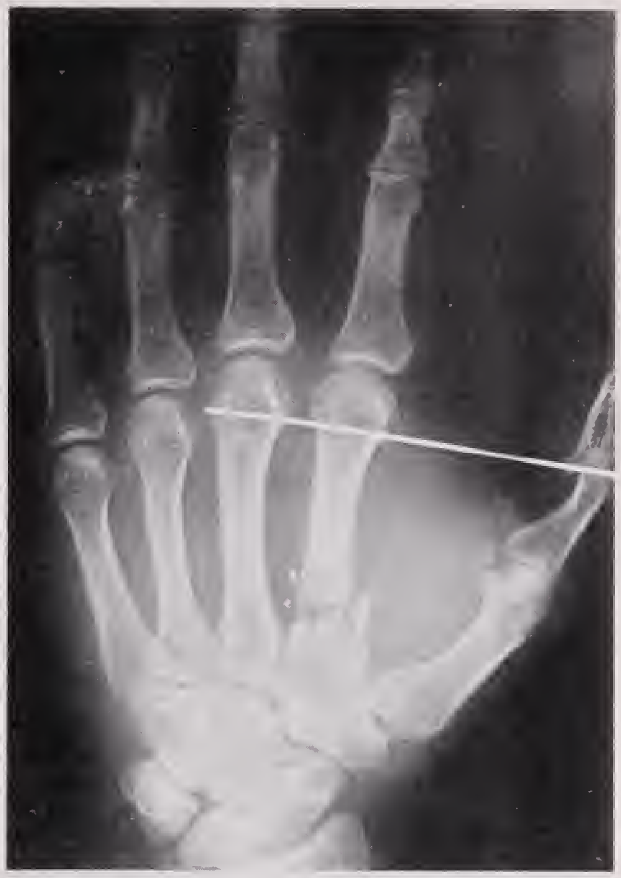

Fig. 3 Transverse pinning of a comminuted index metacarpal fracture maintains length and alignment.

A comminuted fracture can be treated by cross-pinning the thumb metacarpal to the index metacarpal or application of a cast and use of an outrigger for traction (Fig. 5). Oblique and comminuted fractures predispose to shortening and malrotation. If the reduction is unstable, then skeletal traction applied by a transverse Kirschner wire through the metacarpal is satisfactory.

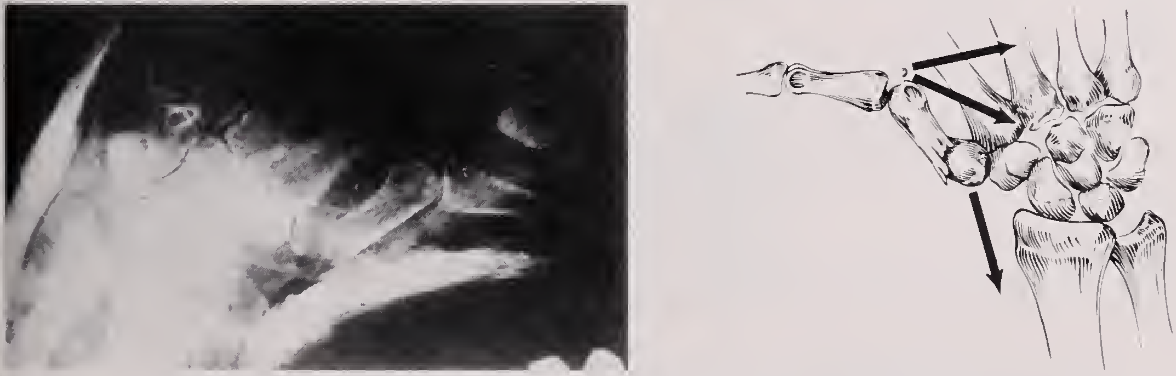

Fig. 4 *(Left)* This transversed fracture of a thumb metacarpal has not been adequately reduced. (From Weeks, P. M., Wray, R. C.: Management of Acute Hand Injuries. C. V. Mosby Co., St. Louis, Mo., 1973.) *(Right)* The pull of the intrinsic muscles attaching to the sesamoid bones of the thumb produce flexion of the distal segment. The abductor pollicis longus inserting into the base of the thumb metacarpal hyperextends the proximal fragment.

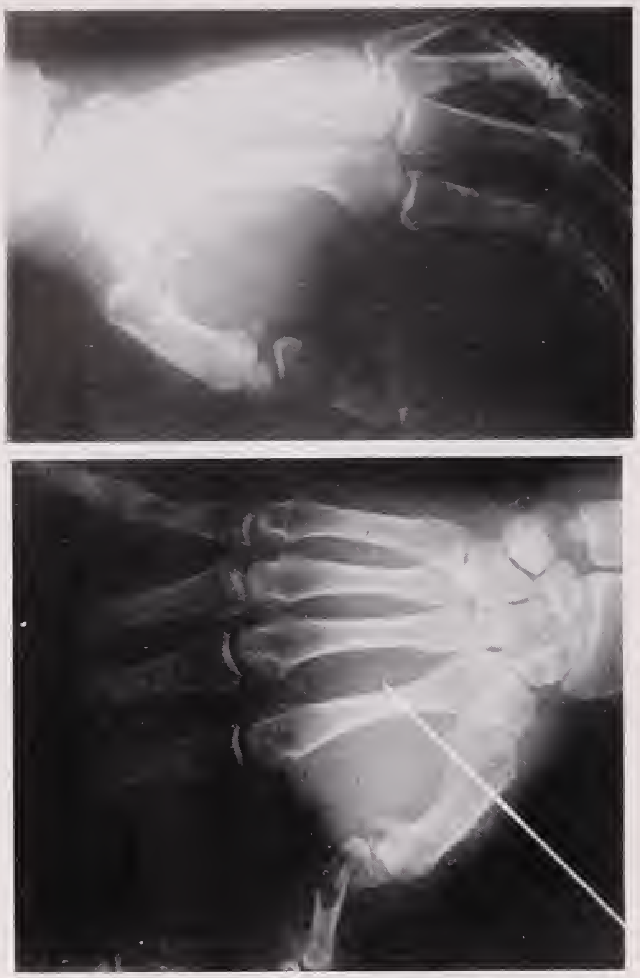

Fig. 5 *(Top)* A compound comminuted fracture with dislocation of the thumb metacarpal. *(Bottom)* Direct pinning of the thumb metacarpal to the index metacarpal provides stabilization, proper alignment of the fragment, and maintains the length of the thumb metacarpal.

Fractures Associated with Crush Injuries

The extensive soft-tissue damage caused by the crushing injury evokes marked tissue edema and subsequent fibrosis about the gliding structures (tendons and joints). To allow early mobilization in an effort to minimize functional loss due to fibrosis, we generally stabilize fractures with internal fixation devices. This allows early (five to seven days after injury) passive and active motion of the tendons and joints.

Evaluation of Results

Evaluation of function reveals that patients with crush injuries of the metacarpals and phalanges have the poorest results. Furthermore, there is a direct relation between the period of immobilization and the final result. Wright observes that uniformly poor results are obtained in fractures immobilized for more than three weeks.[3] In patients whose fractures of metacarpals and phalanges were immobilized longer than three weeks, more than 60% demonstrate significant loss of hand function. This loss of hand function was seen even when the initial fracture was relatively minor. Early mobilization decreases edema and reduces the severity of adhesions around tendons and joints. Concern for elbow and shoulder should be maintained and appropriate exercises instituted.

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In Memoriam

Bart F. Wooldridge, M.D., Medical Arts Bldg., Joplin, a graduate of Vanderbilt University, 1947; member of Jasper County Medical Society; age 50; died Sept. 26, 1974.

John M. Parato, M.D., 10 Westmoreland Pl., St. Louis, a graduate of Royal University, 1927; member of St. Louis Medical Society; age 73; died Nov. 16, 1974.

Richard V. Riddell, M.D., 902 Edmond, St. Joseph, a graduate of Harvard University, 1942; member Buchanan County Medical Society; age 58; died Nov. 27, 1974.

William H. Walters, M.D., 3608 S. Grand, St. Louis, a graduate of St. Lous University, 1920; member of St. Louis Medical Society; age 83; died Dec. 9, 1974.

Freeman L. Finley, M.D., 2475 Hartland, St. Louis, a graduate of Kentucky School of Medicine, 1903; member of St. Louis County Medical Society; age 94; died Dec. 13, 1974.

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James P. Keating, M.D., 500 S. Kingshighway, St. Louis, has become a member of St. Louis Medical Society. Dr. Keating is a native of Philadelphia, received his preliminary education at Harvard University and his M.D. degree at Harvard University in 1963. He specializes in pediatrics.

F. Delbert Moeller, M.D., Barnes Hospital Plaza, St. Louis, has become a member of St. Louis Medical Society. Dr. Moeller is a native of Alabama, received his M.D. degree at Ohio State University in 1969. He specializes in obstetrics and gynecology.

Gordon J. Montgomery, M.D., 2601 N. Whittier, St. Louis, has become a member of St. Louis Medical Society. Dr. Montgomery is a native of Indiana, received his preliminary education at the University of Cincinnati and his M.D. degree at Howard University in 1972. He specializes in ophthalmology.

Mary E. Mullen, M.D., 6420 Clayton Rd., St. Louis, has become a member of St. Louis Medical Society. Dr. Mullen is a native of Wisconsin, received her preliminary education at St. Louis University and her M.D. degree at St. Louis University in 1967. She specializes in internal medicine.

Gary H. Myers, M.D., 2821 N. Ballas Rd., St. Louis, has become a member of St. Louis Medical Society. Dr. Myers is a native of Minnesota, received his preliminary education at the University of Minnesota and his M.D. degree at the University of Minnesota in 1968. He specializes in neurology.

Michael Reveley, M.D., 4940 Audubon, St. Louis, has become a member of St. Louis Medical Society. Dr. Reveley is a native of Texas, received his preliminary education at the University of Texas and his M.D. degree at Southwestern Medical School in 1970. He specializes in psychiatry.

Luis H. Robles, M.D., 777 N. Blue Parkway, Lee's Summit, has become a member of Jackson County Medical Society. Dr. Robles is a native of

(Continued on page 93)

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Precautions: Addiction (dependency) to diphenoxylate HCl is theoretically possible at high dosage. Do not exceed recommended dosages. Administer with caution to patients receiving addicting drugs or known to be addiction prone or having a history of drug abuse. The subtherapeutic amount of atropine is added to discourage deliberate overdosage; strictly observe contraindications, warnings and precautions for atropine; use with caution in children since signs of atropinism may occur even with the recommended dosage.

Adverse reactions: Atropine effects include dryness of skin and mucous membranes, flushing and urinary retention. Other side effects with Lomotil include nausea, sedation, vomiting, swelling of the gums, abdominal discomfort, respiratory depression, numbness of the extremities, headache, dizziness, depression, malaise, drowsiness, coma, lethargy, anorexia, restlessness, euphoria, pruritus, angioneurotic edema, giant urticaria and paralytic ileus.

Dosage and administration: ***Lomotil is contraindicated in children less than 2 years old.*** Use only Lomotil liquid for children 2 to 12 years old. For ages 2 to 5 years, 4 ml. (2 mg.) t.i.d.; 5 to 8 years, 4 ml. (2 mg.) q.i.d.; 8 to 12 years, 4 ml. (2 mg.) 5 times daily; adults, two tablets (5 mg.) t.i.d. to two tablets (5 mg.) q.i.d. or two regular teaspoonfuls (10 ml., 5 mg.) q.i.d. Maintenance dosage may be as low as one fourth of the initial dosage. Make downward dosage adjustment as soon as initial symptoms are controlled.

Overdosage: Keep the medication out of the reach of children since accidental overdosage may cause severe, even fatal, respiratory depression. Signs of overdosage include flushing, lethargy or coma, hypotonic reflexes, nystagmus, pinpoint pupils, tachycardia and respiratory depression which may occur 12 to 30 hours after overdose. Evacuate stomach by lavage, establish a patent airway and, when necessary, assist respiration mechanically. Use a narcotic antagonist in severe respiratory depression. Observation should extend over at least 48 hours.

Dosage forms: Tablets, 2.5 mg. of diphenoxylate HCl with 0.025 mg. of atropine sulfate. *Liquid,* 2.5 mg of diphenoxylate HCl and 0.025 mg. of atropine sulfate per 5 ml. A plastic dropper calibrated in increments of ½ ml. (total capacity, 2 ml.) accompanies each 2-oz. bottle of Lomotil liquid.

SEARLE **Searle & Co.**
San Juan, Puerto Rico 00936

Address medical inquiries to:
G. D. Searle & Co.
Medical Department, Box 5110,
Chicago, Illinois 60680

454 R

When diarrhea has his number...

37
10
8
7
12
1
NIM

Lomotil puts him back in the game.

Physicians and patients both want prompt control of the symptoms of diarrhea. A rapid, uncontrolled loss of fluids and electrolytes can cause a medical crisis, particularly in children, and in patients who are seriously ill, or in people who are badly undernourished.

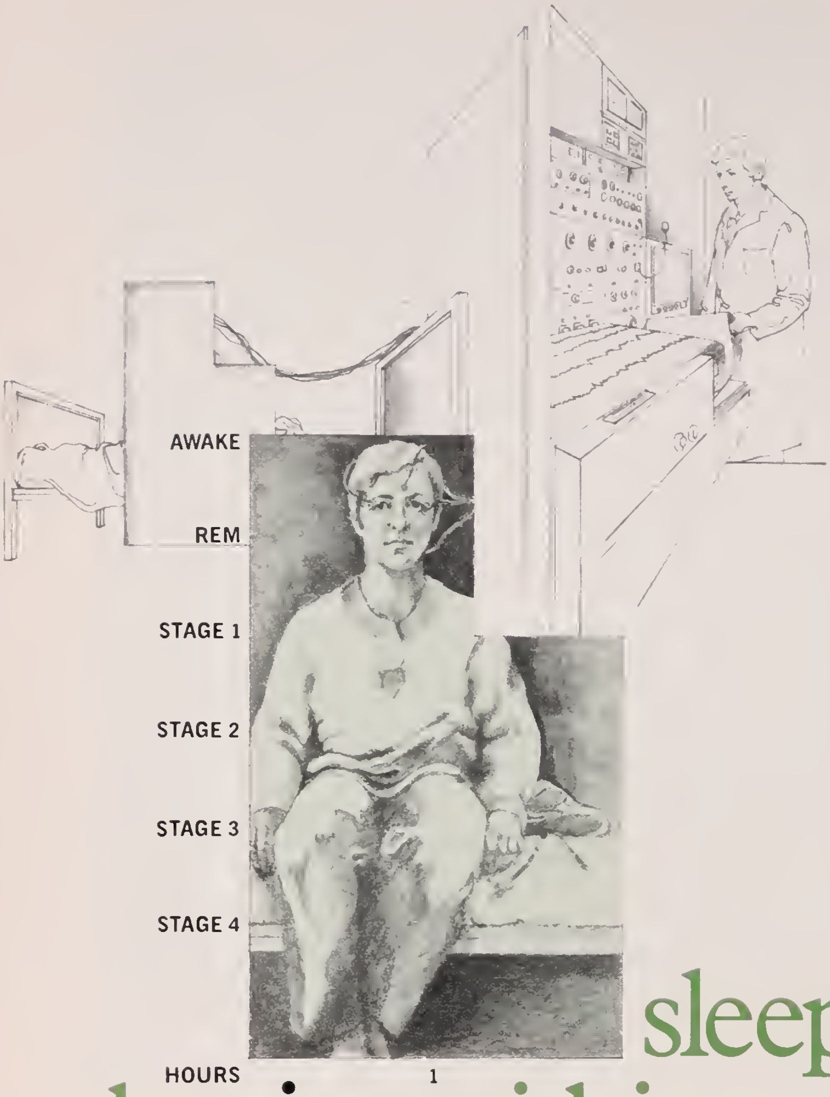
Lomotil usually stops diarrhea promptly. This rapid action halts the emergency aspect of diarrhea and is comforting and reassuring to the patient. Electrolyte and fluid losses can be corrected while the specific cause of the diarrhea is being determined. If an infective agent is the cause, appropriate antibiotic therapy should be given along with Lomotil.

Lomotil has few side effects, and those that do occur are generally mild.

Lomotil®
TABLETS/LIQUID

Each tablet and each 5 ml. of liquid contain:
diphenoxylate hydrochloride ...... 2.5 mg.
(Warning: May be habit forming)
atropine sulfate .... 0.025 mg.

Usually stops diarrhea promptly.



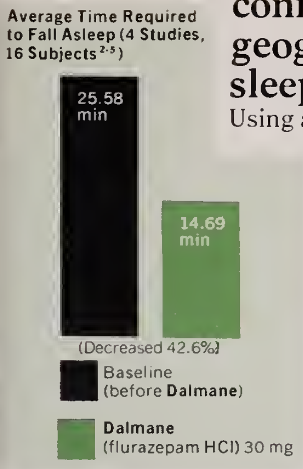
sleep begins within 17 minutes, on average... an initial benefit of

Dalmane®

(flurazepam HCl)

proved by a 22-night clinical study of insomnia patients in the sleep research laboratory and at home[1]

Three insomnia patients selected for difficulty falling asleep were administered Dalmane (flurazepam HCl) 30 mg for 14 consecutive nights. Placebo was given for four nights prior to and four nights after Dalmane. Physiologic tracings on Dalmane nights 1-3 showed sleep induction time averaged 13.90 minutes; on Dalmane nights 12-14, 18.80 minutes. Combined average for the 6 monitored drug nights was 16.35 minutes.[1]



confirmed by clinical studies in four geographically separated sleep research laboratories[2-5]

Using a 14-night protocol involving eight insomniac and eight normal subjects, four studies confirmed the sleep-inducing effectiveness of Dalmane (flurazepam HCl) and the reproducibility of this response. On average, one 30-mg capsule induced sleep within 17 minutes. In all these studies, Dalmane induced sleep rapidly, reduced nighttime awakenings, and provided 7 to 8 hours of sleep without repeating dosage[2-5]

Dalmane (flurazepam HCl) induces and maintains sleep, with relative safety

Dalmane is generally well tolerated; morning "hang-over" has been relatively infrequent. While dizziness, drowsiness, lightheadedness and the like have been noted most often, particularly in the elderly and debilitated, physicians should be aware of the possibility of more serious reactions, as noted below.

Before prescribing Dalmane (flurazepam HCl), please consult Complete Product Information, a summary of which follows:

Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; and in acute or chronic medical situations requiring restful sleep. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended.

Contraindications: Known hypersensitivity to flurazepam HCl.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. Caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Use in women who are or may become pregnant only when potential benefits have been weighed against possible hazards. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated, initial dosage should be limited to 15 mg to preclude oversedation, dizziness and/or ataxia. If combined with other drugs having hypnotic or CNS-depressant effects, consider potential additive effects. Employ usual precautions in patients who are severely depressed, or with latent depression or suicidal tendencies. Periodic blood counts and liver and kidney function tests are advised during repeated therapy. Observe usual precautions in presence of impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported were headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins and alkaline phosphatase. Paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity, have also been reported in rare instances.

Dosage: Individualize for maximum beneficial effect. *Adults:* 30 mg usual dosage; 15 mg may suffice in some patients. *Elderly or debilitated patients:* 15 mg initially until response is determined.

Supplied: Capsules containing 15 mg or 30 mg flurazepam HCl.

when restful sleep is indicated

Dalmane®

(flurazepam HCl)

One 30-mg capsule *h.s.* — usual adult dosage (15 mg may suffice in some patients).
One 15-mg capsule *h.s.* — initial dosage for elderly or debilitated patients.

- induces sleep within 17 minutes, on average
- reduces nighttime awakenings
- sustains sleep 7 to 8 hours, on average, without repeating dosage

---

REFERENCES: 1. Kales A, *et al*: *Arch Gen Psychiatry 23*:226-232, Sep 1970
2. Karacan I, Williams RL, Smith JR: The sleep laboratory in the investigation of sleep and sleep disturbances. Scientific exhibit at the 124th annual meeting of the American Psychiatric Association, Washington DC, May 3-7, 1971
3. Frost JD Jr: Data on file, Medical Department, Hoffmann-La Roche Inc, Nutley NJ
4. Vogel GW: Data on file, Medical Department, Hoffmann-La Roche Inc, Nutley NJ
5. Dement WC: Data on file, Medical Department, Hoffmann-La Roche Inc, Nutley NJ

ROCHE

ROCHE LABORATORIES
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

Before prescribing, see complete prescribing information in SK&F literature or *PDR*. The following is a brief summary.

Indications: Edema associated with congestive heart failure, cirrhosis of the liver, the nephrotic syndrome; steroid-induced and idiopathic edema; edema resistant to other diuretic therapy. Also, mild to moderate hypertension.

Contraindications: Pre-existing elevated serum potassium. Hypersensitivity to either component. Continued use in progressive renal or hepatic dysfunction or developing hyperkalemia.

Warnings: Do not use dietary potassium supplements or potassium salts unless hypokalemia develops or dietary potassium intake is markedly impaired. Enteric-coated potassium salts may cause small bowel stenosis with or without ulceration. Hyperkalemia (>5.4 mEq/L) has been reported in 4% of patients under 60 years, in 12% of patients over 60 years, and in less than 8% of patients overall. Rarely, cases have been associated with cardiac irregularities. Accordingly, check serum potassium during therapy, particularly in patients with suspected or confirmed renal insufficiency (e.g., elderly or diabetics). If hyperkalemia develops, substitute a thiazide alone. If spironolactone is used concomitantly with 'Dyazide', check serum potassium frequently—both can cause potassium retention and sometimes hyperkalemia. Two deaths have been reported in patients on such combined therapy (in one, recommended dosage was exceeded; in the other, serum electrolytes were not properly monitored). Observe patients on 'Dyazide' regularly for possible blood dyscrasias, liver damage or other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving Dyrenium (triamterene, SK&F). Rarely, leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with the thiazides. Watch for signs of impending coma in acutely ill cirrhotics. Thiazides are reported to cross the placental barrier and appear in breast milk. This may result in fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly other adverse reactions that have occurred in the adult. When used during pregnancy or in women who might bear children, weigh potential benefits against possible hazards to fetus.

Precautions: Do periodic serum electrolyte and BUN determinations. Do periodic hematologic studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in post-sympathectomy patients. The following may occur: hyperuricemia and gout, reversible nitrogen retention, decreasing alkali reserve with possible metabolic acidosis, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), digitalis intoxication (in hypokalemia). Use cautiously in surgical patients. Concomitant use with antihypertensive agents may result in an additive hypotensive effect.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis; rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting (may indicate electrolyte imbalance), diarrhea, constipation, other gastrointestinal disturbances. Rarely, necrotizing vasculitis, paresthesias, icterus, pancreatitis, and xanthopsia have occurred with thiazides alone.

Supplied: Bottles of 100 capsules; in Single Unit Packages of 100 (intended for institutional use only).

SK&F CO.
Carolina, P.R. 00630
Subsidiary of
SmithKline Corporation

KEEP THE HYPERTENSIVE PATIENT ON THERAPY KEEP THERAPY SIMPLE WITH

DYAZIDE®

Trademark

Each capsule contains 50 mg. of Dyrenium* (brand of triamterene) and 25 mg. of hydrochlorothiazide.

Just 'Dyazide' once daily or twice daily
No inconvenient potassium supplements
Nor special K+ rich diets needed as a rule

20
40
60
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300

Two prime reasons patients drop out of hypertensive therapy are (1) the patient failed to understand directions, and (2) the regimen was overly complicated. Dosage is simple with 'Dyazide', easily understood, once or twice daily, depending on response. There's no need to complicate the regimen with potassium supplements or unwieldy potassium-rich diets.

TO KEEP BLOOD PRESSURE DOWN AND KEEP POTASSIUM LEVELS UP

Putting out the fires of arthritic pain

Rheumatoid arthritis can sometimes spread like wildfire, with joint after joint going up inflamed: "The usual onset is manifested by spotty joint involvement but an acute onset of symmetrical polyarthritis may be noted."*

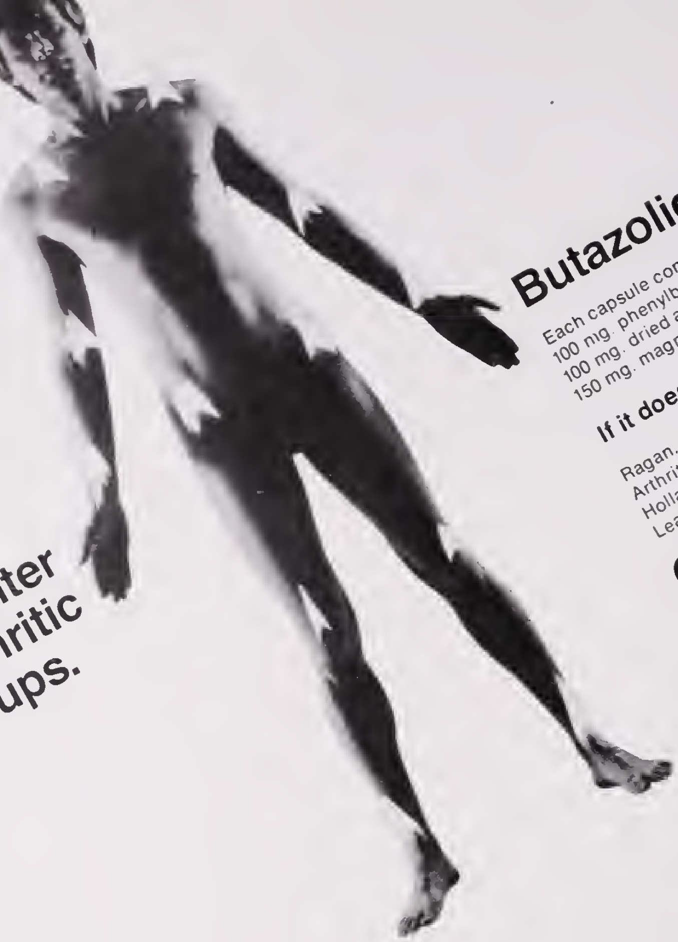
If aspirin fails, consider Butazolidin alka. Giving one capsule four times a day often provides prompt, pain-relieving, anti-inflammatory action to help restore joint mobility. The results you can get within a week can be maintained on as little as one or two capsules daily.

Serious side effects can occur. Select patients carefully (particularly the elderly) and follow them closely in line with the drug's precautions, warnings, contraindications and adverse reactions. For full details, please read the prescribing information. It's summarized on the back of this page.

Butazolidin® alka

Each capsule contains:
100 mg. phenylbutazone USP
100 mg. dried aluminum hydroxide gel USP
150 mg. magnesium trisilicate USP

If it doesn't work in a week, forget it.



Fire fighter
for arthritic
flare-ups.

Butazolidin® alka

Each capsule contains:
100 mg. phenylbutazone USP
100 mg. dried aluminum hydroxide gel USP
150 mg. magnesium trisilicate USP

If it doesn't work in a week, forget it.

Ragan, C.: The Clinical Picture of Rheumatoid Arthritis, in Arthritis, ed. 8, edited by J. L. Hollander and D. J. McCarty, Jr., Philadelphia, Lea & Febiger, 1972, chap. 21, p. 335.

Geigy

Important Note: This drug is not a simple analgesic. Do not administer casually. Carefully evaluate patients before starting treatment and keep them under close supervision. Obtain a detailed history, and complete physical and laboratory examination (complete hemogram, urinalysis, etc.) before prescribing and at frequent intervals thereafter. Carefully select patients, avoiding those responsive to routine measures, contraindicated patients or those who cannot be observed frequently. Warn patients not to exceed recommended dosage. Short-term relief of severe symptoms with the smallest possible dosage is the goal of therapy. Dosage should be taken with meals or a full glass of milk. Substitute alka capsules for tablets if dyspeptic symptoms occur. Patients should discontinue the drug and report immediately any sign of: fever, sore throat, oral lesions (symptoms of blood dyscrasia), dyspepsia, epigastric pain, symptoms of anemia, black or tarry stools or other evidence of intestinal ulceration or hemorrhage, skin reactions, significant weight gain or edema. A one-week trial period is adequate. Discontinue in the absence of a favorable response. Restrict treatment periods to one week in patients over sixty.
Indications: Rheumatoid arthritis, osteoarthritis, bursitis, acute gouty arthritis and rheumatoid spondylitis.
Contraindications: Children 14 years or less, senile patients; history or symptoms of G.I. inflammation or ulceration including severe, recurrent or persistent dyspepsia, history or presence of drug allergy, blood dyscrasias, renal, hepatic or cardiac dysfunction, hypertension, thyroid disease, systemic edema, stomatitis and salivary gland enlargement due to the drug, polymyalgia rheumatica and temporal arteritis, patients receiving other potent chemotherapeutic agents, or long-term anticoagulant therapy.
Warnings: Age, weight, dosage, duration of therapy, existance of concomitant diseases, and concurrent potent chemotherapy affect incidence of toxic reactions. Carefully instruct and observe the individual patient, especially the aging (forty years and over) who have increased susceptibility to the toxicity of the drug. Use lowest effective dosage. Weigh initially unpredictable benefits against potential risk of severe, even fatal, reactions. The disease condition itself is unaltered by the drug. Use with caution in first trimester of pregnancy and in nursing mothers. Drug may appear in cord blood and breast milk. Serious, even fatal, blood dyscrasias, including aplastic anemia, may occur suddenly despite regular hemograms, and may become manifest days or weeks after cessation of drug. Any significant change in total white count, relative decrease in granulocytes, appearance of immature forms, or fall in hematocrit should signal immediate cessation of therapy and complete hematologic investigation. Unexplained bleeding involving CNS, adrenals, and G.I. tract has occurred. The drug may potentiate action of insulin, sulfonylurea, and sulfonamide-type agents. Carefully observe patients taking these agents. Nontoxic and toxic goiters and myxedema have been reported (the drug reduces iodine uptake by the thyroid). Blurred vision can be a significant toxic symptom worthy of a complete ophthalmological examination. Swelling of ankles or face in patients under sixty may be prevented by reducing dosage. If edema occurs in patients over sixty, discontinue drug.
Precautions: The following should be accomplished at regular intervals: Careful detailed history for disease being treated and detection of earliest signs of adverse reactions, complete physical examination including check of patient's weight, complete weekly (especially for the aging) or an every two week blood check; pertinent laboratory studies. Caution patients about participating in activity requiring alertness and coordination, as driving a car, etc. Cases of leukemia have been reported in patients with a history of short- and long-term therapy. The majority of these patients were over forty. Remember that arthritic-type pains can be the presenting symptom of leukemia.
Adverse Reactions: This is a potent drug; its misuse can lead to serious results. Review detailed information before beginning therapy. Ulcerative esophagitis, acute and reactivated gastric and duodenal ulcer with perforation and hemorrhage, ulceration and perforation of large bowel, occult G.I. bleeding with anemia, gastritis, epigastric pain, hematemesis, dyspepsia, nausea, vomiting and diarrhea, abdominal distention, agranulocytosis, aplastic anemia, hemolytic anemia, anemia due to blood loss including occult G.I. bleeding, thrombocytopenia, pancytopenia, leukemia, leukopenia, bone marrow depression, sodium and chloride retention, water retention and edema, plasma dilution, respiratory alkalosis, metabolic acidosis, fatal and nonfatal hepatitis (cholestasis may or may not be prominent), petechiae, purpura without thrombocytopenia, toxic pruritus, erythema nodosum, erythema multiforme, Stevens-Johnson syndrome, Lyell's syndrome (toxic necrotizing epidermolysis), exfoliative dermatitis, serum sickness, hypersensitivity angiitis (polyarteritis), anaphylactic shock, urticaria, arthralgia, fever, rashes (all allergic reactions require prompt and permanent withdrawal of the drug), proteinuria, hematuria, oliguria, anuria, renal failure with azotemia, glomerulonephritis, acute tubular necrosis, nephrotic syndrome, bilateral renal cortical necrosis, renal stones, ureteral obstruction with uric acid crystals due to uricosuric action of drug, impaired renal function, cardiac decompensation, hypertension, pericarditis, diffuse interstitial myocarditis with muscle necrosis, perivascular granulomata, aggravation of temporal arteritis in patients with polymyalgia rheumatica, optic neuritis, blurred vision, retinal hemorrhage, toxic amblyopia, retinal detachment, hearing loss, hyperglycemia, thyroid hyperplasia, toxic goiter, association of hyperthyroidism and hypothyroidism (causal relationship not established), agitation, confusional states, lethargy. CNS reactions associated with overdosage, including convulsions, euphoria, psychosis, depression, headaches, hallucinations, giddiness, vertigo, coma, hyperventilation, insomnia; ulcerative stomatitis, salivary gland enlargement.
(B)98-146-070-J (10/71)

For complete details, including dosage, please see full prescribing information.

GEIGY Pharmaceuticals
Division of CIBA-GEIGY Corporation
Ardsley, New York 10502

BU 10259

President's Message

On February 1, a new set of HEW regulations went into effect concerning the hospitalization of patients under Medicare, Medicaid and other government programs. These regulations concern three phases of hospital care:

First: All admissions must be certified as necessary by the Utilization Committee within one working day after admission.

Second: Each hospitalized patient must be reviewed after that patient has exceeded the normal hospital stay for the admitting diagnosis. The patient is then given added days of hospitalization or discharged from the hospital.

Third: An ongoing retrospective review of cases treated to insure proper use of the hospital facilities.

It would be an understatement if I were to say that these regulations were greeted with something less than enthusiasm by the medical profession. I am afraid our profession tends to resist any regulation just on the basis of being regulated and almost regardless of the reasonableness of the regulation.

James C. Cope, M.D.

The fact is that when a physician accepts a patient under any of the government-paid-for programs, he becomes an agent of the government and ceases to be only an agent of the patient he is treating. If he were spending only the patient's money at the request of the patient and were not using a tax-supported hospital, then it would be no one's business how long the patient stayed in the hospital or whether he received good medical care. This is seldom any longer the case. Most of us work in tax- or community-supported hospitals and, therefore, are responsible to the governing unit or to the community that supports the hospital to insure proper use of the facility.

The several billion dollars a year that are spent on Medicare are spent at the request of and under the supervision of the physicians. The same is true of Blue Cross, Blue Shield and the other insurance companies. This aggregate insurance pool is collected from the public for use by the public in securing medical care. How these monies are spent is entirely up to the physicians of the nation and, until now, there has been very little supervision or direction of the spending.

Woman's Auxiliary

50th Anniversary

"The old order changes, yielding place to new."—Tennyson

Changes are constantly taking place in the Auxiliary. The Woman's Auxiliary to the American Medical Association will vote on a name change at the Annual Convention in June. Since men are now eligible for membership by virtue of being married to a doctor, they are being welcomed into many auxiliaries. Hence, the new name being suggested is the American Medical Association Auxiliary. In addition to being more acceptable to the male members, the new name moves the group up alphabetically from "W" to "A."

Mrs. George J. Lytton
President

Another change will affect the county auxiliaries. Programs which formerly were provided by the AMA Auxiliary are being restructured. In a process called "from the bottom up" by some, new programming will be developed by the county auxiliaries and will be fed into a Clearing House. Thus, various county programs which have been successful will be made available to all auxiliaries in the United States. It is hoped that these programs will be more relevant to all organizations.

One thing which never changes is the need for new members. Mrs. Betty Liljestrand, President of the Woman's Auxiliary to the American Medical Association, stated it very cleverly when she addressed the Clinical Meeting of the AMA: "Your 180,000 members must have more than 90,000 wives." In Missouri, there surely are more than 1,700 married doctors. No wife will join if her husband is not enthusiastic. Weigh the advantages of her belonging to an exciting organization whose major purpose is to advance the cause of medicine. Then urge your wife to join.

Together, we can do much more.

EDITORIAL

STATE MEDICAL JOURNALS HEAD THE LIST

State medical journals have received another vote of confidence from their readers.

This year, ten of the state journals in the 36-journal group* to which this journal belongs were tested by a professional research group in Philadelphia and set a record of which we may be very proud.

The testing mechanism, which is as objective as it is possible to be, consists of attaching valid bank checks for $5.00 to advertising pages and then counting the number of checks which are cashed within ten weeks after mailing.

The journal copies to be decorated with the checks are selected by an independent certified public accountant. Physicians' names are chosen from the mailing list by serial numbers so that the selection is completely at random.

The checks are distributed through the various journal copies so that, in the end, each one of the advertising pages has been labeled as often as all the other ad pages in that issue.

During 1973 and 1974, our own state journal group and 16 of the most popular nationally distributed association sponsored and commercial medical publications have been tested by this technic.

The ten state medical journals had an average score of 35%. This is an extremely high response. Usually returns on such tests are considered good if they are between 20% and 25%.

The scores for the other 16 national publications varied from 34.6% down to 15.4%. The state journal group was at the head of the list.

Measuring a publication's ad-page-exposure record by the $5 check technic is the most reliable method yet devised. Every effort was made by the researcher to assure the highest standards of precision and accuracy. Standard procedures, without deviation, were employed on all journals.

The entire process is scrupulously conducted so as to avoid bias. The results may be accepted as truly indicative of a publication's ability to attract and interest its readers, the physicians. All state journals may feel complimented and honored by such a study.

Corroborative evidence of the high readership of state journals is furnished by another type of reader interest study which was done by Medico Media Audit in June and July of this year. **State medical journals as a group headed the list of the ten publications which were studied.**

These two readership audits are considered the most objective and most reliable of all the advertising surveys. The fact that state journals are at the top of each list indicates a consistency and reliability of a medical journalism medium which is most commendable.

—***Journal of the Indiana State Medical Association***

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* The 36-journal group is the State Medical Journal Advertising Bureau, Inc. of which MISSOURI MEDICINE is a member.

Continuing Education Coming Events

(Continued from page 64)

March 13-14	**Seminar: Highlights of Gastroenterology** The Danciger Institute for the Health Sciences Menorah Medical Center, Kansas City
March 18	**Children's Orthopedics** N.W. Mo. Chapter, Missouri Academy of Family Physicians and K.U. School of Medicine Moila Temple, St. Joseph
March 24-26	**Symposium: Surgery** Postgraduate Education K.U. Medical Center, Kansas City, Kan.

County Society News

FIRST DISTRICT

COUNCILOR
JOHN N. MARTIN, M.D., ST. JOSEPH

Buchanan County Medical Society

Forty-five physicians from St. Joseph and Northwest Missouri attended the first meeting of the Buchanan County Medical Society in 1975. President William B. O'Connor presided at the event which included a dinner preceding a business session and scientific program.

Dr. Charles E. Brackett, neurosurgeon from the University of Kansas Medical Center, presented the program and discussed "Care of Critical Problems in Neurosurgery." He was enthusiastic about recent progress in the handling of neurosurgical problems, particularly in the areas of anesthesia and microsurgery.

Dr. Robert B. Stuber introduced Dr. Brackett.

Meeting arrangements were made by the Society's program committee members who are Dr. Edward H. Andres, chairman, and Dr. Stuber and Dr. Wallace McDonald.

Carl K. Ness, M.D., *Secretary*

NOTE:

This new Reciprocity Arrow is designed to speed payment to you

N123

When you see the Reciprocity Arrow on an out-of-area patient's Blue Shield card, it means he has a special arrangement with St. Louis Blue Shield for the payment of UCR benefits. Simply send your regular St. Louis Blue Shield Physicians Service Report to us, being sure to include the patient's Reciprocity number in the space provided on the report form. We'll pay your benefits direct and settle with the patient's Plan later.

Another of the many ways Blue Shield — St. Louis tries to help.

**Blue Shield
St. Louis**

NON PROFIT/COMMUNITY SERVICE ®

TENTH DISTRICT

COUNCILOR
EUGENE T. HANSBROUGH, M.D.
POPLAR BLUFF

Mineral Area Medical Society

The Mineral Area Medical Society held its annual Medical-Legal Banquet for members of the Bar Association of the Judicial Circuit on January 6 at the St. Francois Country Club.

After dinner, a brief business meeting was conducted by President Norma Farmer. Dr. William Nicolay and Dr. Victor Bentinganin of Fredericktown were welcomed as new members.

Dr. Eugene T. Hansbrough of Poplar Bluff, Councilor for the MSMA Tenth District, addressed the group about the necessity for the special assessment to meet AMA indebtedness this year. He assured the members that efforts to prevent further indebtedness and definite financing would be secured.

James Dexter, M.D., Professor of Neurology at the University of Missouri School of Medicine and Assistant Dean of the School, then presented an address on "Knitting the Ravelled Sleeve—The Function of Sleep." His speech was unusually well received and stimulated almost an hour of questions and discussion after his formal presentation.

Forty-four members and guests attended the meeting.

C. W. Chastain, M.D., *Secretary*

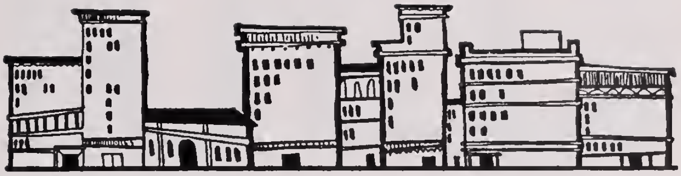
The advertising in

MISSOURI MEDICINE

keeps you informed and helps pay the publishing costs!

When the local representative calls, tell him you saw his company's ad in your journal.

From the Medical Schools



WASHINGTON UNIVERSITY

The Washington University Cancer Center is finalizing plans to construct a new large facility for basic research in cancer-related fields.

Samuel B. Guze, M.D., vice-chancellor for medical affairs and Cancer Center director, said that nearly $1 million will be spent for central facilities for tissue culture cell and virus production and for electron microscopy. These facilities will be located on the eighth floor of the McDonnell Medical Sciences Building in what is presently shell space.

Application made to the National Cancer Institute for $733,438 for construction has been approved and is awaiting funding. The University has committed an additional $244,479.

Robert E. Thach, Ph.D., professor of biological chemistry and Cancer Center associate director for basic research, said that the National Cancer Institute also had approved the application for $1,114,859 for the first three years of operation of the facilities.

Heschel J. Raskas, Ph.D., associate professor of pathology and of microbiology, will be the director of the tissue culture facility.

The National Heart and Lung Institute has approved a five-year grant of approximately $5 million for heart disease research at the School of Medicine.

Burton E. Sobel, M.D., associate professor of medicine and director of the Cardiovascular Division, is principal investigator of a newly established Specialized Center of Research (SCOR) funded by the grant. The St. Louis Center, one of seven in the nation, will concentrate on studies of ischemic heart disease (inadequate blood circulation in the heart due to obstruction of the arteries) which is a major cause of heart attacks. The grant provides funding for more than 20 scientists working in five core facilities and on 11 individual, but integrated, research projects.

UNIVERSITY OF MISSOURI-COLUMBIA

A specially equipped facility for the care of severely burned patients to be established at the University of Missouri-Columbia Medical Center will be known as the *George David Peak Memorial Burn Unit.*

Construction of the unit and provisions for its equipment are made possible by a gift to the University from Mr. and Mrs. George W. Peak of Columbia, whose son died three years ago this month.

George David Peak was one of the original members of the Emergency Medical Services team at the University Medical Center when it was established in 1969 and was enroute to South Missouri to conduct a training class for ambulance technicians when the light plane in which he was traveling crashed in bad weather. He also had been a member of the Boone County Volunteer Fire Department.

The unit will be the first special burn treatment facility to be established in rural Missouri between Kansas City and St. Louis.

Development of a burn center for patients brought to the Medical Center has been a longstanding goal of the "burn team," a group of general and plastic surgeons, physiatrists, nurses and other health professionals who have been actively involved in the treatment of burn patients.

This team cares for more than 80 severely burned patients each year, hospitalizing them now in areas shared with other general medical and/or surgical patients. Hospital director *Joe Greathouse, Jr.* said that the benefits of centralizing the burn patients and personnel resources in a specific location will include better continuity of care for the patients and more effective use of personnel, supplies and equipment.

ST. LOUIS UNIVERSITY

Two major appointments have been announced at the St. Louis University School of Medicine.

Announcement of the appointment of *Dr. David Reynolds Challoner* as the new dean of the School of Medicine was made on Jan. 1, 1975.

Dr. Challoner will hold the faculty rank of professor of internal medicine. He comes from Indiana University School of Medicine in Indianapolis, where he has served as professor of medicine and biochemistry. He joined the faculty there in 1967.

Dr. Challoner

He earned the M.D. degree at Harvard Medical School in 1961. His premedical studies were taken at Lawrence College in Appleton, Wisc., where he earned the B.S. Degree in 1956.

Dr. Challoner stated, "My own basic approach is relatively traditional, and there will be no radical experiments in medical education under my administration. I believe strongly in the grounding of the basic medical sciences as a foundation for clinical practice."

Dr. Challoner will assume the deanship on March 1, 1975 succeeding *Dr. Robert Hanna Felix,* who served as dean of the School from October, 1962 until he was named dean emeritus in June, 1974. He is now program coordinator of the Bi-State Regional Medical Program.

Dr. Stephen M. Ayres has been appointed as the new professor and chairman of the Department of Internal Medicine at the St. Louis University School of Medicine and physician-in-chief at the St. Louis University Hospitals. His appointment became effective on Jan. 1, 1975.

Dr. Ayres

Dr. Ayres is from the University of Massachusetts Medical School in Worchester, Mass. where he has been professor of medicine and chief of the Department of Medicine at St. Vincent's Hospital in Worchester.

Dr. Ayres described the approach of his work as being the development of cardiopulmonary physiology and applying those techniques to the critically ill individual.

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PRESCRIBING INFORMATION

Antiminth (pyrantel pamoate) Oral Suspension

Actions. Antiminth (pyrantel pamoate) has demonstrated anthelmintic activity against *Enterobius vermicularis* (pinworm) and *Ascaris lumbricoides* (roundworm). The anthelmintic action is probably due to the neuromuscular blocking property of the drug.

Antiminth is partially absorbed after an oral dose. Plasma levels of unchanged drug are low. Peak levels (0.05-0.13μg/ml.) are reached in 1-3 hours. Quantities greater than 50% of administered drug are excreted in feces as the unchanged form, whereas only 7% or less of the dose is found in urine as the unchanged form of the drug and its metabolites.

Indications. For the treatment of ascariasis (roundworm infection) and enterobiasis (pinworm infection).

Warnings. *Usage in Pregnancy:* Reproduction studies have been performed in animals and there was no evidence of propensity for harm to the fetus. The relevance to the human is not known.

There is no experience in pregnant women who have received this drug.

Precautions. Minor transient elevations of SGOT have occurred in a small percentage of patients. Therefore, this drug should be used with caution in patients with pre-existing liver dysfunction.

Adverse Reactions. The most frequently encountered adverse reactions are related to the gastrointestinal system.

Gastrointestinal and hepatic reactions: anorexia, nausea, vomiting, gastralgia, abdominal cramps, diarrhea and tenesmus, transient elevation of SGOT.

CNS reactions: headache, dizziness, drowsiness, and insomnia. Skin reactions: rashes.

Dosage and Administration. *Children and Adults:* Antiminth Oral Suspension (50 mg. of pyrantel base/ml.) should be administered in a single dose of 11 mg. of pyrantel base per kg. of body weight (or 5 mg./lb.); maximum total dose 1 gram. This corresponds to a simplified dosage regimen of 1 cc. of Antiminth per 10 lb. of body weight. (One teaspoonful = 5 cc.)

Antiminth (pyrantel pamoate) Oral Suspension may be administered without regard to ingestion of food or time of day, and purging is not necessary prior to, during, or after therapy. It may be taken with milk or fruit juices.

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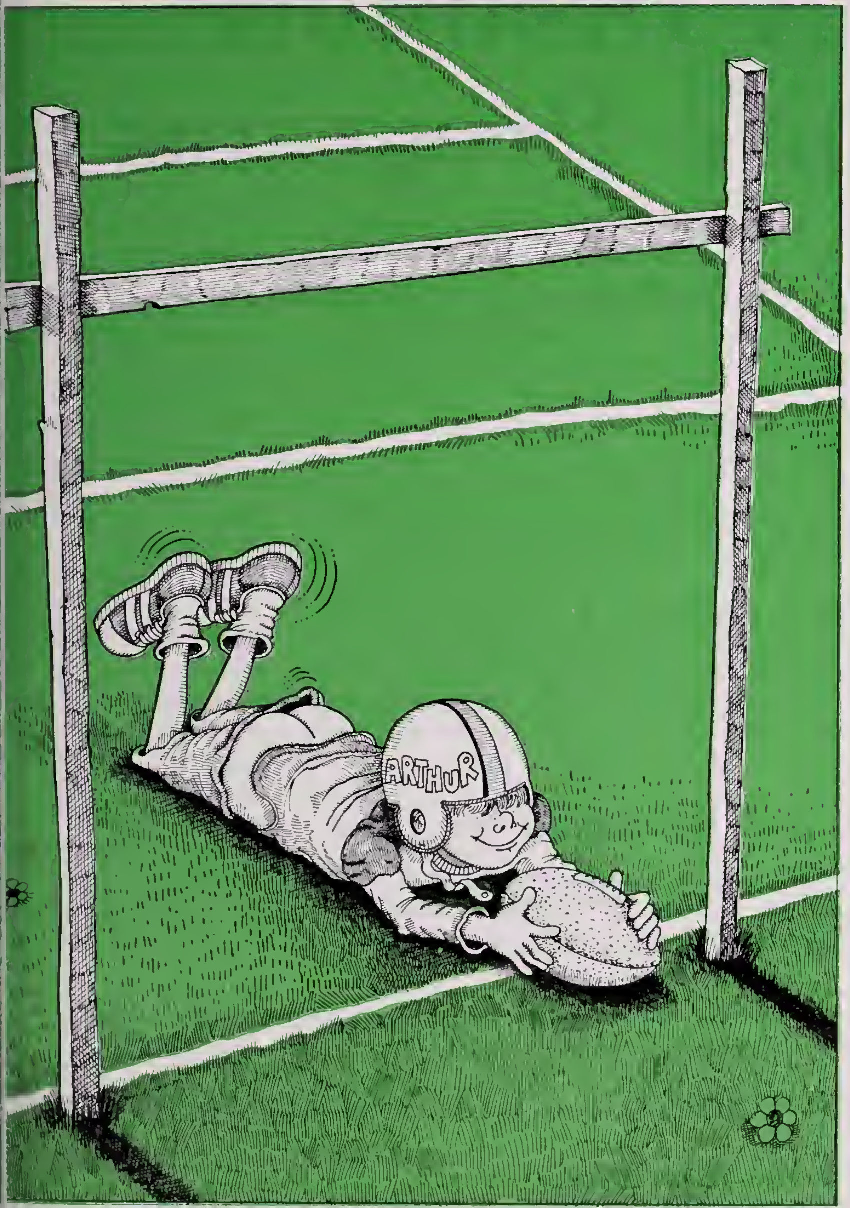

A single dose of Antiminth (1 cc. per 10 lbs. of body weight, 1 tsp./50 lbs. — maximum dose, 4 tsp.=20 cc.) offers highly effective control of *both* pinworms and roundworms.

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New Members

(Continued from page 84)

Peru, received his preliminary education at the University of San Marcos and his M.D. degree at the University of San Marcos in 1968. He specializes in internal medicine.

Bharat K. Shah, M.D., 2601 N. Whittier, St. Louis, has become a member of St. Louis Medical Society. Dr. Shah is a native of India, received his preliminary education at Gujarat College and his M.D. degree at G. S. Medical College in 1964. He specializes in general surgery.

John J. Sheridan, M.D., 6651 Chippewa, St. Louis, has become a member of St. Louis Medical Society. Dr. Sheridan is a native of St. Louis, received his preliminary education at the University of Notre Dame and his M.D. degree at Washington University in 1969. He specializes in orthopedic surgery.

Lawrence S. Shields, M.D., Taylor Health Center, Southwest Missouri State University, Springfield, has become a member of Greene County Medical Society. Dr. Shields is a native of St. Louis, received his preliminary education at St. Louis University and his M.D. degree at the University of Missouri in 1970. He is in clinical family practice.

Mickey Shintaku, M.D., 1325 S. Grand, St. Louis, has become a member of St. Louis Medical Society. Dr. Shintaku is a native of Illinois, received his preliminary education at the University of California and his M.D. degree at St. Louis University in 1972. He specializes in orthopedic surgery.

Paul D. Shuff, M.D., 1035 Bellevue, St. Louis, has become a member of St. Louis Medical Society. Dr. Shuff is a native of Ohio, received his preliminary education at Notre Dame University and his M.D. degree at St. Louis University in 1969. He specializes in otorhinolaryngology.

Barry Silverman, M.D., 4940 Audubon, St. Louis, has become a member of St. Louis Medical Society. Dr. Silverman is a native of Texas, received his preliminary education at Duke University and his M.D. degree at the University of Texas in 1974. He specializes in psychiatry.

Vichien Sinsakul, M.D., St. Louis VA Hospital, St. Louis, has become a member of St. Louis Medical Society. Dr. Sinsakul is a native of Thailand, received his preliminary education at Chulalongkorn College of Science and his M.D. degree at the University of Medical Science in 1963. He specializes in internal medicine.

Alan R. Spivack, M.D., 10511 Old Olive St. Road, St. Louis, has become a member of St. Louis County Medical Society. Dr. Spivack is a native of St. Louis, received his preliminary education at Washington University and his M.D. degree at St. Louis University in 1964. He specializes in internal medicine.

Sirivella Srikrishna, M.D., 3015 N. Ballas Rd., St. Louis, has become a member of St. Louis Medical Society. Dr. Srikrishna is a native of India and received his M.D. degree at Guntur Medical College in 1968. He specializes in surgery.

John J. Stamatis, M.D., 609 Cherry, Springfield, has become a member of Greene County Medical Society. Dr. Stamatis is a native of Oklahoma City, Okla., received his preliminary education at Westminster College and his M.D. degree at Oklahoma University in 1967. He specializes in thoracic and cardiovascular surgery.

William K. Sullivan, M.D., Scott Air Force Base, USAF Medical Center, Scott AFB, Ill., has become a member of St. Louis County Medical Society. Dr. Sullivan is a native of St. Louis, received his preliminary education at United States Military Academy and his M.D. degree at the University of Missouri in 1974. He is in general practice.

Pedro L. Suarez, M.D., 1360 S. Fifth, St. Charles, has become a member of St. Charles-Lincoln County Medical Society. Dr. Suarez is a native of Santiago de Cuba, received his preliminary education at the Institutio Segunda Ensenanza and his M.D. degree at Havana University in 1957. He specializes in psychiatry.

W. Richard Sylvanovich, M.D., 615 S. New Ballas Rd., St. Louis, has become a member of St. Louis Medical Society. Dr. Sylvanovich is a native of Poland and received his M.D. degree at the Academy of Medicine in 1962. He specializes in internal medicine and gastroenterology.

Santon W. Taglia, M.D., 2850 Clay, St. Charles, has become a member of St. Charles-Lincoln County Medical Society. Dr. Taglia is a native of Chicago, Ill., received his preliminary education at DePaul University and his M.D. degree at the University of Bologna in 1967. He is in general practice.

Charles H. Tan, M.D., St. Louis VA Hospital, St. Louis, has become a member of St. Louis County Medical Society. Dr. Tan is a native of Peiping, China, received his preliminary education at National Taiwan University and his M.D. degree at National Taiwan University in 1956. He specializes in internal medicine.

Vunnee Thanapaisal, M.D., 2601 N. Whittier, St. Louis, has become a member of St. Louis Medical Society. Dr. Thanapaisal is a native of Thailand and received her M.D. degree at Siriraj Medical School in 1965. She specializes in pediatrics.

Robert E. Tobin, M.D., 1817 N. Belt, St. Joseph, has become a member of Buchanan County Medical Society. Dr. Tobin is a native of Glen Cove, N. Y., received his preliminary education at St. Michaels College and his M.D. degree at Creighton University in 1970. He specializes in ophthalmology.

Benesto F. Tumanut, M.D., 6700 Troost, Kansas City, has become a member of Jackson County Medical Society. Dr. Tumanut is a native of the Philippines, received his preliminary education at the University of Santo Tomas and his M.D. degree at the University of Santo Tomas in 1965. He specializes in otorhinolaryngology.

James R. Vighi, M.D., 2860 W. Clay, St. Charles, has become a member of St. Charles-Lincoln County Medical Society. Dr. Vighi is a native of Ottawa, Ill., received his preliminary education at St. Mary's College and his M.D. degree at St. Louis University in 1965. He specializes in otolaryngology.

Bruce J. Walz, M.D., 510 S. Kingshighway, St. Louis, has become a member of St. Louis Medical Society. Dr. Walz is a native of Illinois and received his M.D. degree at Washington University in 1966. He specializes in radiation therapy.

Hubert K. W. Wang, M.D., 3400 Frederick, St. Joseph, has become a member of Buchanan County Medical Society. Dr. Wang is a native of Nang Chang, China and received his M.D. degree at National Taiwan University in 1964. He specializes in neurology.

Eng Chuan T. Wee, M.D., 2601 N. Whittier, St. Louis, has become a member of St. Louis Medical Society. Dr. Wee is a native of the Philippines and received his M.D. degree at the University of Santo Tomas in 1963. He specializes in ophthalmology.

Zila Welner, M.D., 500 S. Kingshighway, St. Louis, has become a member of St. Louis County Medical Society. Dr. Welner is a native of Tel-Aviv, Israel, received his preliminary education at Hebrew University and his M.D. degree at Hebrew University in 1960. He specializes in child psychiatry.

The Council Reports

(Continued from page 68)

"Section 1. Members of this Association shall be physicians whose names have been certified by secretaries of component societies to the Secretary of this Association that they are duly elected members of a component society and are legally qualified physicians practicing in Missouri and are members of the American Medical Association except as otherwise provided. Each member must be of good moral and professional standing, and must not support, nor practice, nor claim to practice any exclusive system of medicine."

3. Amend Chapter VIII, Section 1(a) of the Bylaws by striking out Section 1(a) of Chapter VIII and inserting in lieu thereof the following:

"Section 1. (a) The annual dues of this Association shall be $90.00, which shall be applicable to each active member of the Association beginning in 1975 and shall be levied per capita on the active members of the component societies; the per capita levy for junior members shall be $10.00 per year; honor and associate members shall not be required to pay dues. Dues shall be payable on January 1 of the year for which they are levied. Any forgiveness of the dues and assessments of the AMA shall be in accordance with rules and regulations of that Association."

4. Amend Chapter VIII, Section 4, of the Bylaws by striking out Section 4 of Chapter VIII and inserting in lieu thereof the following:

"Section 4. The Secretary of each component society shall cause to be collected and remitted to the Treasurer of this Association the dues and capita levies of this Association and the dues and assessments of the American Medical Association. Any member whose name has not been reported for enrollment and whose dues, capita levies of this Association and dues and assessments of the American Medical Association have not been remitted to the Treasurer of this Association on or before March 1 of each year shall stand suspended until his name is properly reported and his dues, capita levies and assessments for the current year are paid. On December 31 of each year, members delinquent in payment of such dues and assessments, or any part thereof shall, ipso facto, forfeit their memberships. No suspended member shall be eligible to register at an annual session."

Motion was made, duly seconded and adopted to accept Recommendation #2 as information.

Recommendation #3—Resolution 5—MSMA Parliamentary Procedure—It is recommended that Resolution 5 introduced in the 1974 House of Delegates be re-referred to a Reference Committee during the 1975 Annual Session. If after hearing testimony in support of this resolution the Reference Committee recommends adoption of Sturgis Standard Code of Parliamentary Procedure in lieu of Roberts Rules of Order and if the House of Delegates adopts the recommendations of the Reference Committee, the Committee on Constitution and Bylaws recommends the following change in the Bylaws:

"Chapter X. Rules of Order. The deliberations of this Association shall be conducted in accordance with parliamentary usage as defined in Sturgis Standard Code of Parliamentary Procedure."

Motion was made by Dr. Hansbrough that Recommendation #3 be accepted and supported. Motion was seconded and adopted.

Motion was made, duly seconded and adopted to accept the report as a whole.

REPORT OF THE COMMITTEE ON VOLUNTARY HEALTH AGENCIES

Dr. William Allen, Chairman of the Committee, stated that a list of Voluntary Health Agencies in Missouri had been published in the July 15 issue of Missouri Medicine.

It was recommended that if each organization listed would be willing to supply funds, that the list published in the July 15, 1975 issue be expanded to include a summary of the purpose, size and type of membership and current activities of each of the organizations listed. Copies of the list would be made available to the Osteopathic Association for distribution to their members.

The Committee also recommended that a meeting of the Committee on Voluntary Health Agencies with representatives of the voluntary health organizations is of sufficient value that it should be continued on an annual basis. It was reported that an estimate of the cost of printing 10,000 copies of the list of voluntary health agencies as outlined above would be $1,500. Dr. Allen stated that if the Council gives approval to the above recommendation, the various voluntary health agencies would be contacted to see if they would be willing to provide funds.

Motion was made by Dr. Hansbrough to accept the report and the recommendation. Motion was seconded and adopted.

REPORT OF AMA DELEGATES

Dr. Peterson stated that quite a lot of things had been done during the AMA Clinical Session in Portland. A special assessment of $60 for a one-year period for AMA members was approved and is effective on Jan. 1, 1975. This was designed to remedy the immediate financial needs of the AMA. A special committee was set up to study the question of a dues increase along with the AMA's financial situation and will report back at the 1975 Annual Meeting.

Dr. Peterson stated that Dr. Malcolm Todd, President of the AMA, had given the best speech of any AMA President that he had heard and he felt that it should be printed either in part or whole as a special article in the Journal.

The House urged the Board of Trustees to restore the structure of several councils and committees and maintain present publication for several AMA publications. The House also approved advertising as a legitimate function in AMA publications.

The House adopted several recommendations in regard to house staffs. It also adopted a report calling for strong programs of continuing medical education and peer review as alternatives to relicensure. The AMA adopted a report containing basic guidelines for NHI deliberations. The AMA House adopted a resolution expressing opposition to U. S. House of Representatives' manpower and planning bills.

A new policy stating that acupuncture should be performed only in research settings by a physician or under the direct supervision of a physician was adopted. A Judicial Council report was adopted which states, "It is not unethical for a physician to authorize the listing of his name and practice in a (community) directory for professional or lay use which is intended to list all physicians in the community on a uniform and nondiscriminatory basis. The listing shall not include any self-aggrandizing statement or qualitative judgment regarding the physician's skills of competence."

Dr. Peterson reported that the disapproval of the special assessment by doctors at large had been recorded three different times during the meeting. The whole financial situation of the AMA had only been called to the attention of everyone approximately three weeks before the meeting and there was really no time to consider any reasonable recommendations and no time for the Delegates to discuss this with their constituents. The entire matter will be brought up at the 1975 Annual Meeting for consideration.

Dr. Peterson stated that doctors should recognize that the AMA is the best organization that doctors have to represent them and we should do everything we can to preserve the AMA.

Motion was made, seconded and carried to approve the AMA Delegate report.

REPORT OF THE WOMAN'S AUXILIARY

Mrs. Lytton passed out copies of the *Missouri Doctor's Wife,* the publication of the MSMA Woman's Auxiliary, and indicated that this is a very fine publication.

The Woman's Auxiliary held its Fall Conference in Springfield in October and had a very good attendance. The program consisted of a panel on aging, presentation on solid waste from the EPA and an excellent presentation on legislation by Dr. Jack Matthews. The Auxiliary gave a donation to the MSMF in Dr. Matthews' name for his excellent participation.

The Environmental Protection Agency has contacted the Woman's Auxiliary as resource people for the advancement of the solid waste program in Missouri. The Auxiliary members will give their services and Mrs. Lytton indicated that they will be willing to help with other programs that the Council feels needs their assistance.

Mrs. Lytton said that she has been doing considerable traveling and stated that she is happy to visit any county which requests. She thanked the Council for their backing of Auxiliary activities.

HR 16204—HEALTH PLANNING BILL

Dr. William Mayer, member of the Executive Committee of the Regional Advisory Group of MRMP and as chairman of MRMP's Transition Committee, gave a presentation regarding HR 16204. This involves the transition of existing separate federal legislation regarding CHP, RMP and Hill-Burton programs to single legislation called the National Health Planning and Development and Health Facilities Assistance Act of 1974. This transition Committee was set up to keep track of the developments of this legislation. MRMP felt that it might be worthwhile to share the knowledge of these developments with MSMA.

Dr. Mayer reported that although the precise format of this legislation is unclear, there is a likelihood that this will become a new law by the time the 93rd Congress adjourns. The Senate passed S.B. 2994 on November 26 and late on December 13, the House passed HR 16204. The Conference Committee is working hard to get this bill out. It is likely that the President will sign it.

Dr. Mayer gave several quotes from the Committee on Labor and Public Welfare Report on November 12, which indicated that a majority of the members of governing bodies of health planning agencies be consumers of health services; that if the plan which emerges is to be viable, the providers of health services influence on the health planning process must be appropriately limited. Dr. Mayer reviewed the nature of the legislation. Although many details are unclear, it establishes three entities: (1) Health Service Areas within states; (2) Statewide Health Coordinating Councils; (3) National Council for Health Policy. It is unclear as to the size of these health agencies. The House version stipulates that the Health Service Areas (HSA's) should be representing populations of one-half million to three million; 200,000 in unusual circumstances and less than 200,000 in very unusual circumstances. The designation of HSA's is left to the Governor. The Senate version does not stipulate size but probably would be the existing "B" Agencies. The HSA's would be the main responsible group for health planning within the state. The functions of the HSA's is slightly unclear and still under some debate. Functions might include planning; review and approval of grants and contracts under numerous federal programs; review and recommendations regarding new institutional health services, health care facilities, HMO's, etc. within HSA. Statewide Health Coordinating Council—the Governor has the authority to designate the state agency responsible.

Dr. Mayer said that he did not feel the functions under this particular bill were really the most important issue, but it lays out a structure which could be of vital importance in the future. The Governor designates the HSA's and the Governor develops mechanisms for designating Health Systems Agencies. He indicated that he felt it is very critical that MSMA keep close tabs on these items. He feels that the providers of health services in this state may have some meaningful comments to make relative to the provision of health services.

Dr. Mayer closed by saying that the Transition Committee of MRMP and the Executive Committee will continue to monitor the developments rather closely and will contact MSMA when there are developments of potential importance.

HOSPITAL DISCHARGE DATA PROGRAM

Dr. Charles Sherwin, St. Louis, accompanied by Mr. John Norwood, Administrator of Bethesda Hospital and Mr. Robert Thebeau, Assistant Executive Director of St. Mary's Health Center, read a proposed resolution opposing the Proposed Uniform Hospital Discharge Data Program of the Division of Health.

It was reported that the scheduled mandatory reporting system set to take effect on January 1 will continue to be voluntary as was the case in the past with the "Icepick Program."

Much discussion followed by Messrs. Thebeau and Norwood as to their concern regarding revealing of confidential information and the cost of securing this information. Dr. Domke spoke on behalf of the Board of Health and the necessity for securing such information, stating that patient confidentiality would definitely be upheld.

Dr. Sherwin stated that in view of the rescinding of the mandatory provisions, he would submit his resolution to the MSMA House of Delegates at the upcoming Annual Session with some revisions.

REPORT OF THE DEANS

Dr. Joseph White, Acting Dean, University of Missouri-Columbia, reported that they have appointed a new Chairman of the Department of Surgery.

Dr. White reported on a method for providing financial support for medical students by a community if the medical student agrees to serve that community for a given period of time. He stated that the University is not involved in this and they do not support it, but wanted to call the Council's attention to it.

Regarding progress of admissions, Dr. White stated that instate applications are down about 100 and out-of-state applications are down about 40%. They still have about the same number of highly qualified applicants from whom to select.

Dr. White reported on the investigation of admissions procedures which took place by a special committee of the Missouri House of Representatives. The Committee asked that the number of students be increased. Dr. White stated that there are two state schools, two private schools and two osteopathic schools; the problem is that not enough students elect to stay and practice in the state of Missouri.

Dr. White reported on several items regarding family practice residents, percentages of money received from the federal government, etc.

Dr. George Thoma, St. Louis University, reported on several appointments recently made by the St. Louis U. Medical Center, including the hiring of a Dean for the Medical School.

Regarding last year's admissions, Dr. Thoma reported that 50% of the class were Missourians and 23% women. These made a grade point average of 3.56. St. Louis University Medical Center is establishing a new Division of Forensic Pathology.

Dr. Richardson K. Noback, Dean of the University of Missouri-Kansas City Medical School, reported that out of 72 new freshmen brought in last fall, only one is in real jeopardy. The University has acquired a new Chairman of the Department of Pathology.

The University of Missouri-Kansas City School of Medicine was dedicated on October 27 and is in use. Truman Medical Center is to be completed by August, 1976. Dr. Noback named several other appointments recently made at the school. He said that the preceptorship program with the Academy of General Practice is in good order.

LEGISLATIVE REPORT

Dr. Matthews discussed the activities of the Legislative Interim Health Committee which included hearings on Surgicenters, Physician Assistants, Acupuncture and Medica Laboratories. To date, a bill has been prefiled to allow establishment of surgicenters. Bills in the other three areas have not yet surfaced.

Dr. Matthews informed the Council that the County Medical Examiner System, passed by the 77th General Assembly, has been declared invalid by the St. Louis Circui Court. Two new bills to reestablish the validity of the Examiner System have been prefiled and will again receive the support of MSMA.

The proposed new Nurses Practice Act, which has been prefiled, also was discussed and no objections to the bill as written were voiced.

In the area of confidentiality of medical information, two state senators have indicated that they plan to prefile measures which will insure confidentiality.

Other matters brought up in the report include prefiled bills on fluoridation; establishment of joint legislative Committee on Health Affairs, establishment of a program fo prevention and control of alcohol, several measures dealing with highway safety and numerous health and accident insurance bills.

A brief discussion followed regarding legislative matters On motion, duly seconded, the report of the Committee on Legislation was accepted. Motion carried.

DIRECTOR, MISSOURI DIVISION OF HEALTH

Dr. Domke, Director of the Missouri Division of Health reported that there has been an epidemic of infectiou syphilis for the past 15 months in the state of Missouri. H indicated that they are getting excellent technical performance, but cannot seem to get the epidemic under control. H indicated that there must be a change in attitude of th private physician in reporting the cases he sees. It is absolutely imperative that physicians report all cases of venereal diseases which they see in their private office.

Dr. Domke reported that they have delivered 41 full equipped ambulances since July 1 and there are 43 more o order right now. There are presently 50 ambulance district in the state.

117TH MSMA ANNUAL SESSION

Mr. Ellison reported that planning for the 117th Annual Session is going along on schedule. Of those specialties which have indicated they will sponsor programs, about one half have sent in their detailed programs. The program will be published in MISSOURI MEDICINE each month beginning with the January issue until the time of the Annual Session. Mr. Ellison asked the Councilors to please inform the MSMA Headquarters office if they plan to hold a breakfast for their delegations. The Annual Meeting will be held at he Chase-Park Plaza Hotel in St. Louis on April 17-20, 1975.

MSMA MALPRACTICE INSURANCE

Mr. McIntyre indicated that Mr. Cooper has been working very closely with Mr. Hamilton and Rollins Burdick Hunter Company regarding MSMA malpractice insurance. He stated that the papers had been signed recently to set up a corporation when and if the program becomes effective. There will have to be a board set up to operate the corporation and there will have to be funds set aside. The Board for the corporation would consist of five Directors—two from MSMA. It was agreed that the President should designate the two MSMA members to the Board of Directors.

NEXT COUNCIL MEETING

The next meeting of the MSMA Council will be held on Saturday, February 8 at the Ramada Inn in Jefferson City. There will be an Executive Meeting of the Council on Friday evening, February 7, at 5 PM followed by dinner.

The meeting adjourned at 4:30 PM.

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Major petrochemical company has opening for REFINERY MEDICAL DIRECTOR in St. Louis area. A challenging new post for a physician strong in clinical, occupational and preventive medicine, with an interest in occupational medical administration. Excellent fringe benefits. Will direct occupational health program for 2,000 employees. 4 nurses in existing department. Salary negotiable.

Previous industrial experience desirable, but not mandatory. Please send resume, with minimum salary requirements, in confidence, to: Box 399, Missouri State Medical Association, 113 Madison, Jefferson City, Mo. 65101.

SITUATION WANTED—General Practitioner, 18 years experience. Would like to join partnership, group or association. Respond to Box 400, Missouri State Medical Association, 113 Madison, Jefferson City, Mo. 65101.

VACATION IN ST. JOHN—U. S. Virgin Islands; clear air and water and unspoiled, primitive beauty. Rates markedly decreased between April 1 and December 15. Angelo Lapi, M.D., 101 Memorial Drive, Kansas City, Mo. 64108.

LOCUM TENENS WORK—Sought by 52-year-old, semi-retired G.P. Twenty-seven years' solo experience in small Missouri town. Credentials upon request. F. A. Elders, M.D., P.O. Box 10, Cuba, Mo. 65453.

FOR SALE—FO 9000PL Polydirectional Colonoscope, 185 cm. New cables, fibers, main flex. shaft with case. Also with FCB-95 Power light supply, air supply, biopsy forceps, Wappler #9110A (80") polypectomy snare. $4,000. For information, please call Dr. Campbell at 816-333-7565.

HANLEY 14 x 17 Vertical X-Ray and Medical Record Cabinets are used in most hospitals in America.

Special new ultrasonic, $399. Physio Therapy—Complete Examining and Reception Room Furniture—Traction Equipment—Hospital Beds—Wheelchairs—Jacuzzi Whirlpools—Oxygen. SOLD & RENTED.

HANLEY MEDICAL EQUIPMENT

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LEO H. POLLOCK, M.D.

Missouri Medicine in Review

FORTY YEARS AGO

It was brought to the attention of the Eleemosynary Board that during the year 1932, facilities which had cost the citizens of the state $20,000 had been utilized for the care of but six patients suffering from cancer. These patients were inmates of the state eleemosynary institutions and the treatment had been administered by physicians who had little interest in the treatment of cancer and who were totally untrained in the use of radiation.

During the summer of 1933, the Eleemosynary Board, with Mr. W. Ed. Jameson as president, requested in a formal resolution that the Cancer Committee of the Missouri State Medical Association formulate a plan whereby the facilities at the State Hospital in Fulton might be made available to a larger number of citizens of the state for the diagnosis and treatment of cancer.

TWENTY-FIVE YEARS AGO

On Nov. 4, 1850, 98 physicians from St. Louis and 38 from other localities in the state met and organized the Missouri State Medical Association. Dr. George Penn, St. Louis County, acted as temporary president until the following officers were elected: President, Dr. F. W. G. Thomas of Boonville; Vice-Presidents—Drs. J. Barnes of St. Louis, B. F. Coulter of Pike County, H. T. Hughes of Lewis County, J. Wood of Clay County, and J. F. Atkinson of Lafayette County; Secretaries, Drs. H. C. Wright of Warren County and J. S. B. Alleyne of St. Louis; Treasurer, Dr. G. Johnson of St. Louis.

Thereafter, the Association met annually in the latter part of April at various places in the state until 1857.

No records have been discovered concerning the Association following the meeting of 1856 until 1867. It is probable that the organization became inactive during and following the Civil War.

In 1867, a committee again acted in planning a session of the Association and a regular meeting was held on April 21, 1868 in St. Louis.

Sessions of the Association were interrupted again in 1945: no session was held that year.

Most of the meetings were held in St. Louis until 1872, although Boonville entertained the Association in 1850, Lexington in 1854 and 1856 and St. Joseph in 1857.

In 1872, it was decided that the objects of the Association could be accomplished more effectively and a greater number of physicians in the state could be brought within its sphere of influence if the annual meetings would be held in different sections of the state.

Since 1850, the number of physicians in Missouri has increased from a mere handful until today there are 3,565 who are members of the Missouri State Medical Association.

TEN YEARS AGO

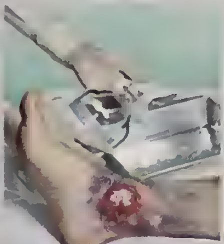
Dr. Charles B. Wheeler of Kansas City, chairman of the MSMA Committee on Laboratory Medicine, reported that his committee favors the creation of a state board of medicolegal examiners. The Council voted to support such legislation in 1965 and, also, to work for passage of a bill to revise the old county coroner system. Dr. Wheeler also won approval for a proposal for introducing a measure which would declare the processing of blood for transfusions to be a medical service and not a sale in the commercial concept of that word.

Walt Disney murals will decorate the walls of the new Children's Mercy Hospital in Kansas City. Joyce C. Hall, head of the well-known Hallmark greeting card company and honorary chairman of Mercy Hospital's current fund raising campaign, made the arrangements through personal contact with Mr. Disney. The world-famous cartoonist is a former Kansas Citian.

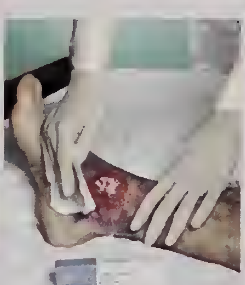
adjunctive therapy for wound debridement

HELPS TO REMOVE:
- Necrotic Tissue and Associated Odor

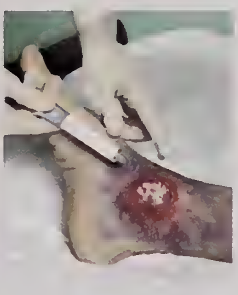
HELPS PREPARE WOUND FOR:
- Granulation/Healing
- Granulation/Grafting



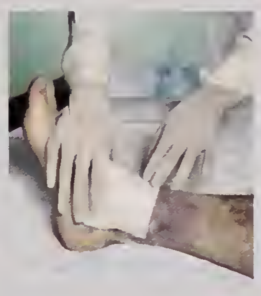
CLEANSE WOUND
Thoroughly cleanse and irrigate wound area with sodium chloride or water solutions. Wound MUST be cleansed of antiseptics or heavy-metal antibacterials.



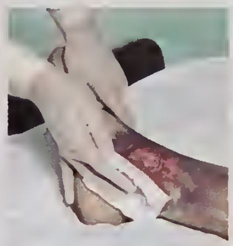
THOROUGHLY MOISTEN
Thoroughly moisten wound area either through tubbing, showering, or wet soaks (e.g., sodium chloride or water solutions).



APPLY ENZYME
Apply a layer of TRAVASE Ointment. Assure intimate contact with necrotic tissue and complete wound coverage.



APPLY MOIST DRESSING
Apply loose moist dressings (most important with dry leathery eschar).



CHANGE DRESSINGS
When changing dressing, gently wipe away the dissolved material. Repeat the procedure, including application of TRAVASE Ointment, 3 to 4 times per day for best results.

Travase® Ointment
brand of Sutilains

Travase® Ointment
brand of Sutilains

Description

Indications
For wound debridement (1,2)—TRAVASE Ointment is indicated as an adjunct to established methods of wound care for biochemical debridement of the following lesions:

Second and third degree burns.
Decubitus ulcers.
Incisional, traumatic, and pyogenic wounds.
Ulcers secondary to peripheral vascular disease.

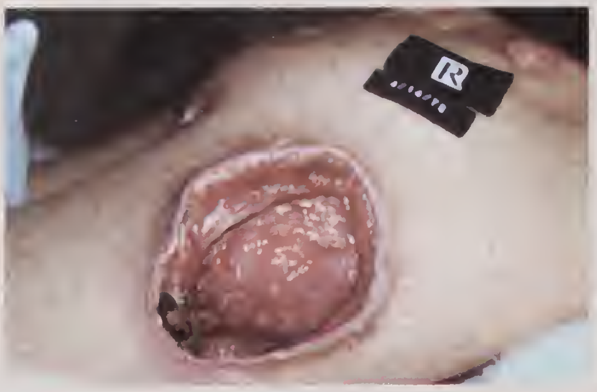
FLINT LABORATORIES
DIVISION OF TRAVENOL LABORATORIES, INC
Deerfield, Illinois 60015

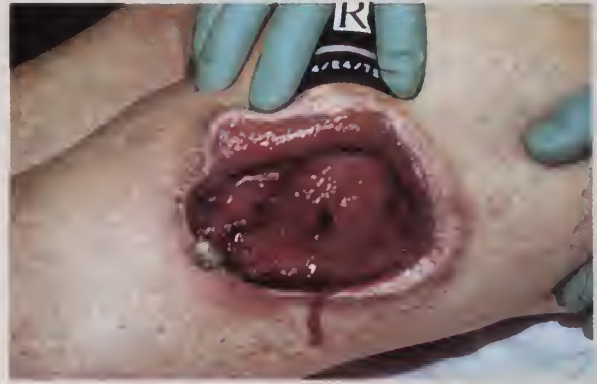
Please see next page for prescribing information.

Travase Ointment brand of Sutilains

ulcers

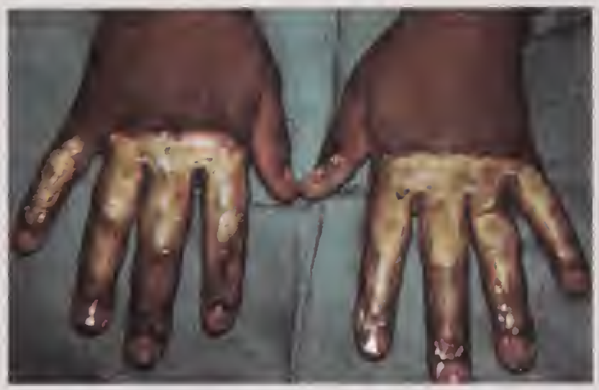
TERRY V. CARLE M.D., CLINICAL INSTRUCTOR, DEPT. OF PHYS. MED. & REHAB.,
CRAIG REHABILITATION HOSPITAL, UNIVERSITY OF COLORADO

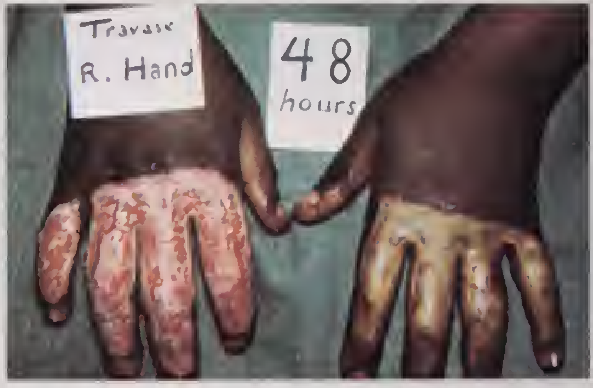

Before treatment, necrotic matter coated the inner surfaces of this decubitus ulcer.


After nine days of TRAVASE therapy, debridement is nearly complete and granulation evident.

burns

DALE B. DUBIN, M.D., DIPLOMATE,
AMERICAN BOARD OF PLASTIC SURGERY TAMPA, FLORIDA


Before treatment . . .



48 hours following treatment with TRAVASE Ointment on right hand; left hand is control.

Travase® Ointment

(brand of Sutilains)

Indications: For wound debridement, TRAVASE Ointment is indicated as an adjunct to established methods of wound care for biochemical debridement of the following lesions:

- Second and third degree burns,
- Decubitus ulcers,
- Incisional, traumatic, and pyogenic wounds,
- Ulcers secondary to peripheral vascular disease.

Contraindications: Application of TRAVASE Ointment is contraindicated in the following conditions:

- Wounds communicating with major body cavities,
- Wounds containing exposed major nerves or nervous tissue,
- Fungating neoplastic ulcers,
- Wounds in women of child-bearing potential—because of lack of laboratory evidence of effects of TRAVASE upon the developing fetus.

Warning: Do not permit TRAVASE Ointment to come into contact with the eyes. If contact is made, immediately rinse with copious amounts of water, preferably sterile.

Precautions: A moist environment is essential to optimal activity of the enzyme. Enzyme activity may also be impaired by certain agents (see package insert). Although there have been no reports of systemic allergic reaction in humans, studies have shown that there may be an antibody response in humans to absorbed enzyme material.

Adverse Reactions: Consist of mild, transient pain, paresthesias, bleeding and transient dermatitis. Pain usually can be controlled by administration of mild analgesics. Side effects severe enough to warrant discontinuation of therapy occasionally have occurred.

If bleeding or dermatitis occurs as a result of the application of TRAVASE Ointment, therapy should be discontinued. No systemic toxicity has been observed as a result of the topical application of TRAVASE Ointment.

DOSAGE AND ADMINISTRATION: STRICT ADHERENCE TO THE FOLLOWING IS REQUIRED FOR EFFECTIVE RESULTS OF TREATMENT:

1. Thoroughly cleanse and irrigate wound area with sodium chloride or water solutions. Wound MUST be cleansed of antiseptics or heavy-metal antibacterials which may denature enzyme or alter substrate characteristics (e.g., hexachlorophene, silver nitrate, benzalkonium chloride, nitrofurazone, etc.).
2. Thoroughly moisten wound area either through tubbing, showering, or wet soaks (e.g. sodium chloride or water solutions).
3. Apply TRAVASE Ointment in a thin layer assuring intimate contact with necrotic tissue and complete wound coverage extending ¼ to ½ inch beyond the area to be debrided.
4. Apply loose wet dressings.
5. Repeat entire procedure 3 to 4 times per day for best results.

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Deerfield, Illinois 60015

The Bactrim T.M. edge

Each tablet contains 80 mg trimethoprim
and 400 mg sulfamethoxazole.

A high assurance of clinical efficacy

- in cystitis, pyelonephritis and pyelitis diagnosed as chronic
- against susceptible strains of the common urinary tract pathogens, usually *E. coli, Klebsiella-Enterobacter, Proteus mirabilis,* and, less frequently, indole-positive proteus species.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Chronic urinary tract infections (primarily pyelonephritis, pyelitis and cystitis) due to susceptible organisms (usually *E. coli, Klebsiella-Enterobacter, Proteus mirabilis,* and, less frequently, indole-positive proteus species).

Note: The increasing frequency of resistant organisms limits the usefulness of antibacterials, especially in chronic and recurrent urinary tract infections.

Contraindications: Hypersensitivity to trimethoprim or sulfonamides; pregnancy; nursing mothers.

Warnings: Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia in elderly patients on diuretics, primarily thiazides. Sore throat, fever, pallor or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted. Data are insufficient to recommend use in infants and children under 12.

Precautions: Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, allergy or bronchial asthma; and in those with glucose-6-phosphate dehydrogenase deficiency, where hemolysis may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function.

Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. *Blood dyscrasias:* Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. *Allergic reactions:* Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. *Gastrointestinal reactions:* Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis. *CNS reactions:* Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. *Miscellaneous reactions:* Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L.E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.

Dosage: Not recommended for children under 12.

Usual adult dosage: Two tablets b.i.d. for 10 to 14 days. For patients with renal impairment:

Creatinine Clearance (ml/min)	Recommended Dosage Regimen
Above 30	Usual standard regimen
15-30	2 tablets every 24 hours
Below 15	Use not recommended

Supplied: Tablets, each containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose® packages of 1000; Prescription Paks of 40, available singly and in trays of 10.

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and 400 mg sulfamethoxazole.

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T.M.

Each tablet contains 80 mg trimethoprim and 400 mg sulfamethoxazole.

A high assurance of antibacterial activity
in cystitis, pyelonephritis and pyelitis diagnosed as chronic and due to susceptible organisms.

Before prescribing, please consult complete product information, a summary of which appears on preceding page.

Missouri Medicine

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EDUCATION FOR THE LEUKEMIA PATIENT, Patricia Vannatta, M.S.P.H., Phyllis Harris, R.N. and Adrena Mazzei, R.N. 143

Special Feature

117th MSMA ANNUAL SESSION PRELIMINARY PROGRAM, DELEGATES AND EXHIBITORS 107

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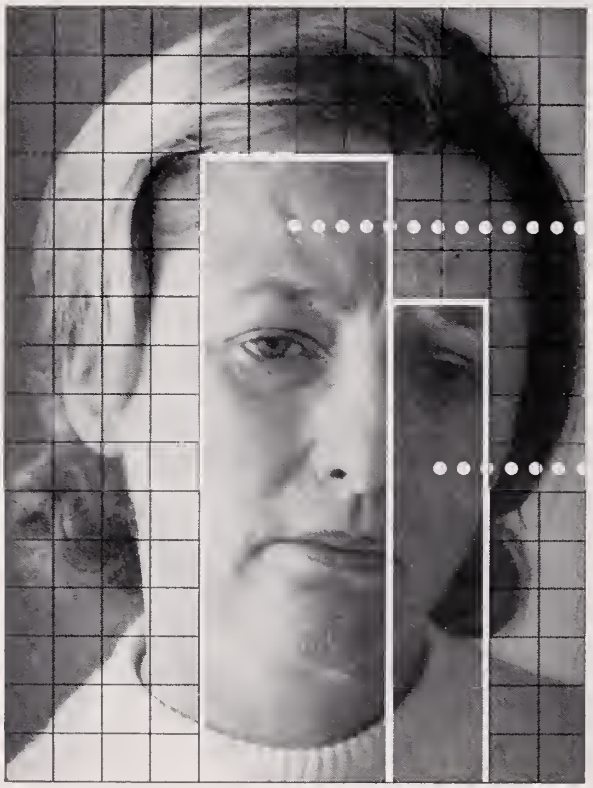
117th MSMA Annual Session
April 17-20, 1975, St. Louis

Both ofte


Predominant psychoneurotic anxiety
Associated depressive symptoms

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in fre
and/or severity of grand mal seizu
require increased dosage of standa
convulsant medication; abrupt wit
may be associated with temporary
crease in frequency and/or severit
seizures. Advise against simultane
gestion of alcohol and other CNS d
sants. Withdrawal symptoms (simi
those with barbiturates and alcoho
occurred following abrupt disconti
(convulsions, tremor, abdominal a
cle cramps, vomiting and sweating
addiction-prone individuals under

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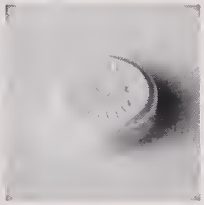
toms, she is a psychoneu-
patient with severe
ty. But according to the
iption she gives of her
gs, part of the problem
ound like depression.
s because her problem,
ugh primarily one of ex-
e anxiety, is often accom-
d by depressive symptom-
gy. Valium (diazepam)
rovide relief for both—as
cessive anxiety is re-
, the depressive symp-
associated with it are also
relieved.
here are other advan-
in using Valium for the
gement of psychoneu-
nxiety with secondary
ssive symptoms: the
otherapeutic effect of
m is pronounced and
This means that im-
ment is usually apparent
in the patient within a few days rather than in a week or two, although it may take longer in some patients. In addition, Valium (diazepam) is generally well tolerated; as with most CNS-acting agents, caution patients against hazardous occupations requiring complete mental alertness.

Also, because the psychoneurotic patient's symptoms are often intensified at bedtime, Valium can offer an additional benefit. An *h.s.* dose added to the *b.i.d.* or *t.i.d.* treatment regimen can relieve the excessive anxiety and associated depressive symptoms and thus encourage a more restful night's sleep.



Valium®
(diazepam)
2-mg, 5-mg, 10-mg tablets

in psychoneurotic
anxiety states
with associated
depressive symptoms

lance because of their predisposi-
habituation and dependence. In
ncy, lactation or women of child-
g age, weigh potential benefit
t possible hazard.
tions: If combined with other psy-
pics or anticonvulsants, consider
lly pharmacology of agents em-
; drugs such as phenothiazines,
cs, barbiturates, MAO inhibitors
ner antidepressants may potentiate
on. Usual precautions indicated in
s severely depressed, or with latent
sion, or with suicidal tendencies.
Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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Missouri Medicine

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Illustrations should be glossy prints or drawings in India ink on white paper. They should not be mounted and name of author and figure number should be penciled lightly on the backs. Legends should appear on a separate sheet. Colored illustrations will be used when suitable if author assumes the actual cost.

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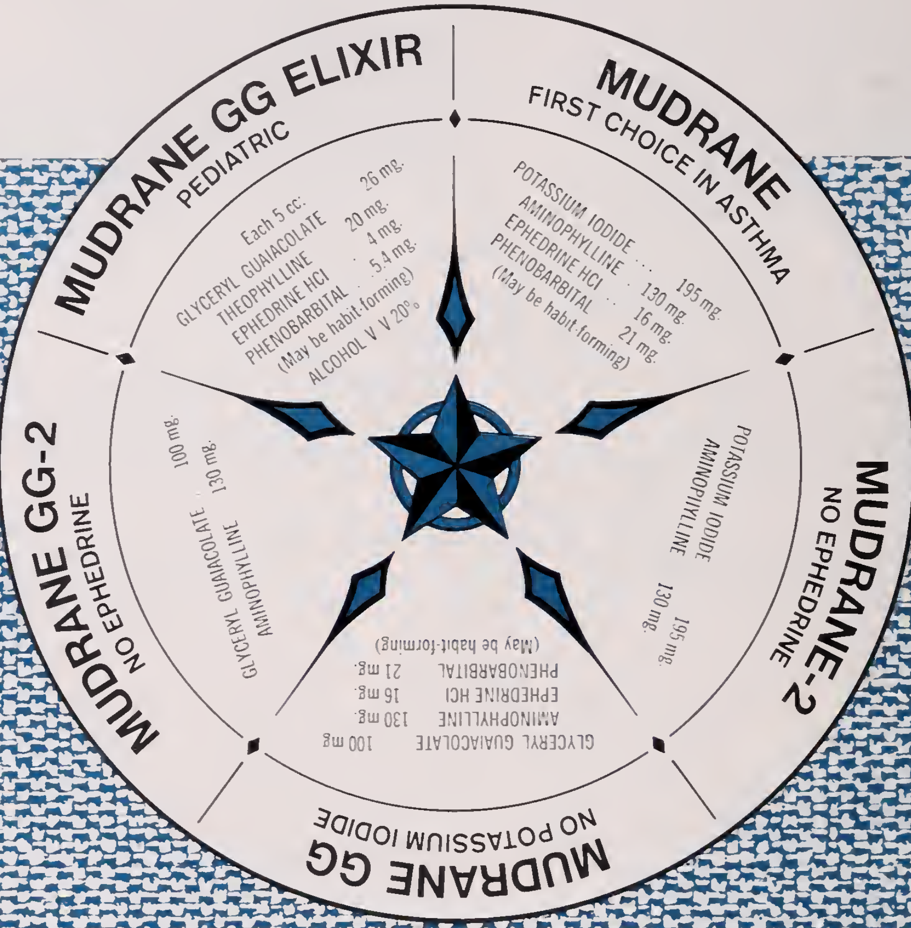
The MUDRANES

Discreet formulations of four well regarded drugs for the relief of bronchial distress—Potassium Iodide, Glyceryl Guaiacolate, Aminophylline, Ephedrine with Phenobarbital (to lessen cardiac stimulation).



MUDRANE
FIRST CHOICE IN ASTHMA

POTASSIUM IODIDE . . . 195 mg.
AMINOPHYLLINE . . 130 mg.
EPHEDRINE HCl . . 16 mg.
PHENOBARBITAL . . 21 mg.
(May be habit-forming)

MUDRANE-2
NO EPHEDRINE

POTASSIUM IODIDE 195 mg.
AMINOPHYLLINE 130 mg.

MUDRANE GG
NO POTASSIUM IODIDE

GLYCERYL GUAIACOLATE 100 mg
AMINOPHYLLINE 130 mg.
EPHEDRINE HCl 16 mg.
PHENOBARBITAL 21 mg.
(May be habit-forming)

MUDRANE GG-2
NO EPHEDRINE

GLYCERYL GUAIACOLATE 100 mg.
AMINOPHYLLINE 130 mg.

MUDRANE GG ELIXIR
PEDIATRIC

Each 5 cc:
GLYCERYL GUAIACOLATE 26 mg.
THEOPHYLLINE 20 mg.
EPHEDRINE HCl . 4 mg.
PHENOBARBITAL . 5.4 mg.
(May be habit-forming)
ALCOHOL V V 20%

INDICATIONS: For the prompt symptomatic relief of bronchial asthma, emphysema and bronchiectasis. The Mudranes dilate the bronchi and liquefy mucus plugs. DOSAGE: Tablet; One tablet with a full glass of water 3 or 4 times daily as required. Divide tablet for child's dose. Elixir; Children, 1 cc for each 10 lbs. of body weight. May be repeated 3 or 4 times a day. Adult, one tablespoonful 4 times daily. All doses should be followed with a glass of water.

CONTRAINDICATIONS: Aminophylline Theophylline is contraindicated in the presence of severe cardiac arrhythmias and patients with massive myocardial damage. Ephedrine, in presence of severe heart disease, extreme hypertension, and in hyperthyroidism. Phenobarbital, in porphyria and in patients with known phenobarbital sensitivity. Potassium Iodide, in pregnancy (to protect the fetus against possible iodine-induced depression of thyroid activity), in tuberculosis (produces gumma dissolution), and in acne; also in the presence of known iodide sensitivity. PRECAUTIONS: Aminophylline Theophylline should be avoided in patients with massive myocardial damage and/or severe cardiac arrhythmias. In children, overdose may cause vomiting, cardiac arrhythmias, and severe agitation. Ephedrine should be used with caution in the presence of severe cardiac disease, particularly arrhythmias and angina pectoris; avoid in hyperthyroidism and severe hypertension. Phenobarbital may be habit-forming. Avoid overdosage. Potassium Iodide: Discontinue in the presence of skin rash, swelling of the eyelids and severe frontal headache. Long use may cause goiter. ADVERSE REACTIONS: Aminophylline Theophylline may cause nausea, cardiac arrhythmias, and aggravate severe myocardial disease. It may cause headaches and tachycardia. Vomiting and dizziness are not uncommon. Ephedrine: In patients hypersensitive to CNS stimulation, ephedrine may cause nervousness, tachycardia, extrasystole and ventricular arrhythmias. May cause urinary retention, especially in the presence of partial prostatic obstruction. Psychoneurosis may be aggravated. Pre-existing anginal pain will be aggravated. Phenobarbital may produce severe skin rash. Avoid overdosage. May be habit-forming. Potassium Iodide may cause nausea. Over very long period of use, iodides cause goiter. Discontinue if patient develops skin rash, eye irritation, eyelid swelling, or severe frontal headache.

HOW SUPPLIED: Mudrane and Mudrane GG available in bottles of 100 and 1000 tablets; Mudrane-2 and Mudrane GG-2 in 100s; Elixir in pints and half-gallons.

Federal law prohibits dispensing without prescription.

WILLIAM P. POYTHRESS & COMPANY, INC., RICHMOND, VIRGINIA 23261

MSMA

NEWS ROUND - UP

MARCH, 1975

Malpractice debate at Annual Session

Although many topics will interest many physi- ns at the 117th Annual Session of the Missouri te Medical Association, the prime area of con- n will probably be the professional liability in- ance situation.

The Annual Session will be held April 17-20, 75, at the Chase-Park Plaza Hotel in St. Louis. gistration begins at 11 a.m., Thursday, April 17, the Regency Room.

The report of the MSMA Medical-Legal Com- ttee dealing with the malpractice insurance blem will be referred to a Reference Commit- at the opening session of the House of Dele- tes at 1:30 p.m. Thursday, April 17. Committee arings begin at 3 p.m. Members are invited to end the Reference Committee hearing to hear up-to-date report and to express their opinions. Also, Frank J. Jirka, M.D., of Illinois, a mem- of the AMA Board of Trustees, will speak on nationwide malpractice insurance problem at MSMA General Luncheon at 12:30 p.m. Satur- y, April 19, in the Chase Club.

Another program which should prove attractive MSMA members will be a discussion of current tional Health Insurance proposals before Con- ess at the Opening General Session, at 9 a.m., iday, April 18. James C. Cope, M.D., of Colum- , President of the MSMA, will moderate the gram. The speakers will be top staff person- l from the Committees of the U. S. Congress ich have the responsibility of considering Na- nal Health Insurance legislation in the current sion of Congress.

Along with the important actions to be consid- d by the MSMA, 14 medical specialty organiza- ns will sponsor 24 scientific sessions during the nual Session. Approval is pending for Elective urs of Continuing Medical Education by the erican Academy of Family Physicians. All phy- ians are invited to attend these sessions.

A Preliminary Program and hotel registration rd have been mailed to all MSMA members. rly registration is suggested. The Preliminary ogram contains a breakdown on all the scientific sions which are scheduled all day Friday and turday.

In a reversal of a trend the past few years, the mber of Technical Exhibitors registered to at- d the Annual Session has shown a large in- ase. To date, 41 Exhibitors have reserved space. ysicians who register at the Exhibit Booths will eligible to win one of four AM-FM Digital Clock-Radios to be awarded during the meeting.

The format of the Annual Past Presidents' Banquet has been changed somewhat this year. The Banquet, to be held at 6:30 p.m. Saturday, April 19, in the Khorassan Room, will include recognition of Past Presidents and 50-Year-Members and will be the scene of the changing of the MSMA gavel from President Cope to President-Elect R. Allen Chandler, of Kansas City.

Schedule of Events

Thursday, April 17

11:00 a.m.	Registration of Delegates, Regency Room
1:30 p.m.	House of Delegates Meeting, Opening Session, Khorassan Room
3:00 p.m.	Reference Committees: Constitution and Bylaws, Chase Club Medical Education & Public Welfare, Palladian Room Necrology, Khorassan Room
3:30 p.m.	Reference Committees: Reports of Officers, Colonial Miscellaneous Affairs, Park Room
4:00 p.m.	Reference Committee: Resolutions, Coach Room

Friday, April 18

8:00 a.m.	Registration, Regency Room
9:00 a.m.	General Session — National Health Insurance, Chase Club Introduction: James C. Cope, M.D., Columbia, MSMA President Speakers: Top staff personnel from the Committees of the U. S. Congress
4:00 p.m.	House of Delegates, Second Session, Khorassan Room

Saturday, April 19

12:30 p.m.	MSMA General Luncheon, Chase Club Guest Speaker: Frank J. Jirka, Jr., M.D., Member, AMA Board of Trustees
6:30 p.m.	Social Hour for Those Attending Banquest, Khorassan Room
7:15 p.m.	Annual Banquet in Honor of Past-Presidents, Khorassan Room

Sunday, April 20

7:30 a.m.	House of Delegates, Breakfast and Final Session, Khorassan Room

(Continued on Next Page)

State plan reviewed, legislation set

Council adopts resolution on malpractice

A status report on the MSMA-sponsored professional liability insurance corporation headlined the Feb. 8 meeting of the MSMA Council.

The Rollins Burdick Hunter Company, which is formulating the insurance program for MSMA, stated that final arrangements should be available by the Annual Session, April 17-20.

The problems of rising malpractice premiums to Missouri physicians and, in some cases, the inability of physicians to attain coverage, were discussed by the Council. A resolution was adopted calling on the MSMA Legislative Committee to develop legislation on:

1. A graduated scale for contingent fees.
2. Mandatory arbitration in malpractice cases.
3. Placing a ceiling on malpractice awards.
4. Replacing current awards system with a Workman's Compensation type of program.

The Legislative Committee expressed concern that it may be too late in the current General Assembly to introduce and pass legislation. However, after consulting with several Senators, Sen. Albert Spradling, Cape Girardeau, introduced Senate Resolution No. 67 calling for a detailed study of the malpractice problem by a select committee of six State Senators.

The Senate quickly passed Resolution 67 and, at this writing, it is possible that the Senate committee will offer a bill which would enable the establishment of a mutual professional liability insurance company by the physicians of Missouri. The committe will offer further possible solutions in th future.

The members of the committee are Sen Spradling, William Cason, Clinton; Mary Gan Kansas City; Richard Webster, Carthage; Pa Bradshaw, Springfield; and Harry Wiggins, Kansa City.

MSMA members will be receiving addition information as progress is made in this area. I the interim, if a member cannot obtain malpra tice coverage, he should contact MSMA Headqua ters at (314) 636-5151.

In other action, the Council:

● **Objected to an abortion report for distributed by the Division of Health as "breach of confidentiality." Since the obje tion, the U.S. Supreme Court has issued a injunction prohibiting the State of Missou from enforcing HB 1211, the newly-enact abortion law, until the high court review the law. Therefore, the abortion repo forms are no longer required, according the Missouri Attorney General's offic which advised the Division of Health on dra ing up the forms.**

● Sent notification of appreciation to Mr. L Hocker, a St. Louis attorney, for his articles the malpractice problem published in a St. Lou newspaper.

● Recognized Ray S. Hollingsworth, M.D., Clinton, for his dedicated service as Secretary the Henry County Medical Society for the past years.

Annual Session

Continued

Following these ceremonies, Mr. Gary Ellison, "Missouri's official Ragtime Piano Player," will provide entertainment for those present. Mr. Ellison, of Springfield, is a devotee of the late Scott Joplin and earned his official title through a Missouri House Representatives resolution.

Again, this year, tickets to the General Luncheon and the Past Presidents' Banquet will be available at the MSMA Registration Desk in the Regency Room.

Meetings of the MSMA House of Delegates are scheduled for 1:30 p.m., Thursday, April 17; 4 p.m. Friday, April 18; and 7:30 a.m. Sunday, April 20.

Some changes will be instituted this year to facilitate House and Reference Committee activities. An Agenda of Subjects will be available for each Reference Committee and all Resolutions will be on line-numbered paper. This should aid members in discussing various portions of a Resolution. Also, when reporting to the House, each Reference Committee will proceed to a second dais to the front of the room so that consultations between the Speaker of the House and the Committee may be made as needed.

Frank J. Jirka Jr., M.D.
AMA Board Member

James C. Cope, M.D.
President

R. Allen Chandler, M.D.
President-Elect

Dr. Chandler to become MSMA President

Leadership of the Missouri State Medical Association will change hands on Saturday night, April 19, 1975, during ceremonies of the Past Presidents Banquet at the 117th Annual Session in the Khorassan Room of the Chase-Park Plaza Hotel in St. Louis.

President James C. Cope, M.D., a Columbia urologist, will present the gavel to President-Elect R. Allen Chandler, M.D., of Kansas City.

Other highlights of the Banquet will be the recognition of Past Presidents of the MSMA and 50-Year-Members. Also, Mr. Gary Ellison, "Missouri's Ragtime Piano Player," will provide entertainment. Mr. Ellison is a devotee of the late Scott Joplin and has been widely acclaimed for his dedication and talent in re-acquainting the world to ragtime music.

President-Elect Chandler has served as MSMA Seventh District Councilor and is Immediate Past Chairman of the MSMA Council. He is a Diplomat in the American College of Surgeons and the International College of Surgery.

Dr. Chandler is Associate Clinical Professor of Surgery at the University of Missouri-Kansas City Medical School, Chief of Staff of St. Mary's Hospital, Kansas City, Past President of Staff of Children's Mercy Hospital, Kansas City, and affiliated with seven hospitals in the Kansas City area.

He is a member of the Jackson County Medical Society and American Medical Association. Other organizations include the Kansas City Surgical Society, Southwest Clinical Society, American Society of Plastic and Reconstructive Surgery, American Society of Aesthetic Plastic Surgery, American Foundation of Plastic Surgery and American Society of Industrial Physicians.

Dr. Chandler is a former member of the Board of Directors of Kansas City Blue Cross and a member of the Medical Advisory Committee of Kansas City Blue Shield.

Dr. Chandler received his undergraduate training at the University of Arkansas and his M.D. Degree from the University of Arkansas School of Medicine. He served his internship and residency in general surgery and plastic and reconstructive surgery at the Kansas City General Hospital and Medical Center.

AMA files suit against government on utilization review

The AMA filed suit against the Department of HEW Feb. 20 to block the new utilization review regulations covering Medicare and Medicaid patients. The suit is the first ever filed against HEW by the AMA. Hearings began Feb. 24 in federal district court in Chicago.

The suit seeks both a preliminary and permanent injunction on the grounds that the regulations violate the Constitutional rights of both patients and physicians, exceed the authority granted to the HEW secretary by the Social Security Act and violate the section of the act that forbids "any federal officer or employee to exercise any supervision or control over the practice of medicine or the manner in which medical services are provided."

The regulations, which became effective Feb. 1 but which have not yet been implemented, require that every decision by a physician to hospitalize a Medicare or Medicaid patient be evaluated by UR committee of the hospital within one working day. Non-physicians may serve on these committees.

The AMA's first legal action against the government was filed Feb. 19, 1974, against the Cost of Living Council. This suit sought an end to medical care controls, which ended three months later when Congress let the Economic Stabilization Act expire.

AMA President Malcolm C. Todd, M.D., said, "We serve notice now that we will oppose every attempt by the government to interfere between a patient and his or her physician. These regulations do precisely that . . . As we stated last year when HEW attempted to impose preadmission certification regulations, we believe all such regulations to be wrong legally, wrong medically, and wrong morally."

He pointed out that the American Hospital Assn. believes that hospitals may have to initiate preadmission review to avoid loss. "This, of course, is what HEW has wanted all along," Dr. Todd said. The HEW objective, cost cutting, will not be achieved by the regulations, he said. "They will increase the cost of care while reducing the quality."

"This is the issue we are putting before the courts and before the American People," Dr. Todd said. "Is the decision that you need hospital care to be made by your doctor — who knows you — or by a physician who does not know you — or worse yet, by a non-physician? The issue is that simple."

Joining the AMA in the suit are ten patients and five Illinois physicians, including Frank J. Jirka, M.D., a member of the AMA Board of Trustees.

In action taken earlier, the Missouri State Medical Association had objected to the utilization review regulations in letters to HEW and Missouri's Congressional Delegation.

Practicing physician omitted from state health Task Force

The Missouri State Medical Association ha objected to the makeup of a Task Force recentl established to make recommendations to the Governor regarding health service areas in Missour as proposed in the "National Health Planning an Resources Development Act of 1974."

In a letter to Gov. Christopher S. Bond, MSM President James C. Cope said that "the omissio of a practicing physician from the Task Force i a serious oversight."

The 9-member panel, which is to offer sugge tions on splitting the state into health servic areas, will submit its ideas — based on geograph and population concentration — to the Governor fo return to the federal government by May 3.

"We feel that the establishment of the propose health service areas in Missouri are most impo tant to the future delivery of quality medical ca which all Missourians deserve and we know it wi be the practicing physician who will direct deli ery of this care," pointed out Dr. Cope.

The Task Force is composed of:

Mr. William Mitchell, Jefferson City, Chai man, representing Missouri CHP.

Mr. Kenneth Bopp, Kansas City, representin Jackson County "B" Area CHP.

William Mayer, M.D., Columbia, and Robe Felix, M.D., St. Louis, representing RMP.

C. Howe Eller, M.D., St. Louis County, repr senting Experimental Health Delivery System.

Herbert R. Domke, M.D., Jefferson City, re resenting Missouri Board of Health.

Mayor Sam Brace, Anderson, representing R gional Planning Commission's Association.

State Representative Harold Lowenstein, Ka sas City, and State Senator Larry Marshall, C lumbia.

Dr. Blanton appointed to Board of Healing Arts

Joseph C. Blanton, M.D., of Sikeston, was r cently appointed to the State Board of Registrati for the Healing Arts by Gov. Christopher S. Bon

Dr. Blanton succeeds Melvin C. Kasten, M.D of Cape Girardeau, whose term has expired. D Blanton, a pediatrician, will serve a term throu September 3, 1978.

Dr. Schwartz honored

Henry G. Schwartz, M.D., the August A. Bus Jr. professor at the Washington University Scho of Medicine, has been named neurosurgeon of t year by Surgical Neurology, the journal of t Congress of Neurological Surgery.

Putting out the fires of arthritic pain

Rheumatoid arthritis can sometimes spread like wildfire, with joint after joint going up inflamed: "The usual onset is manifested by spotty joint involvement but an acute onset of symmetrical polyarthritis may be noted."*

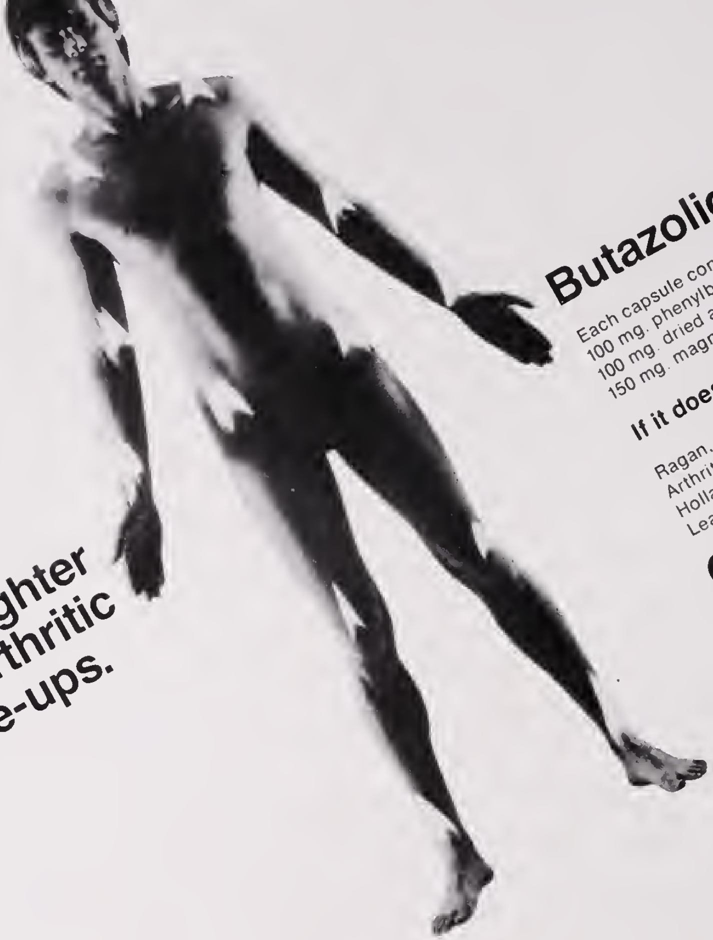
If aspirin fails, consider Butazolidin alka. Giving one capsule four times a day often provides prompt, pain-relieving, anti-inflammatory action to help restore joint mobility. The results you can get within a week can be maintained on as little as one or two capsules daily.

Serious side effects can occur. Select patients carefully (particularly the elderly) and follow them closely in line with the drug's precautions, warnings, contraindications and adverse reactions. For full details, please read the prescribing information. It's summarized on the back of this page.

Butazolidin® alka

Each capsule contains:
100 mg. phenylbutazone USP
100 mg. dried aluminum hydroxide gel USP
150 mg. magnesium trisilicate USP

If it doesn't work in a week, forget it.



Fire fighter for arthritic flare-ups.

Butazolidin® alka

Each capsule contains:
100 mg. phenylbutazone USP
100 mg. dried aluminum hydroxide gel USP
150 mg. magnesium trisilicate USP

If it doesn't work in a week, forget it.

Ragan, C.: The Clinical Picture of Rheumatoid Arthritis, in Arthritis, ed. 8, edited by J. L. Hollander and D. J. McCarty, Jr., Philadelphia, Lea & Febiger, 1972, chap. 21, p. 335.

Geigy

Important Note: This drug is not a simple analgesic. Do not administer casually. Carefully evaluate patients before starting treatment and keep them under close supervision. Obtain a detailed history, and complete physical and laboratory examination (complete hemogram, urinalysis, etc.) before prescribing and at frequent intervals thereafter. Carefully select patients, avoiding those responsive to routine measures, contraindicated patients or those who cannot be observed frequently. Warn patients not to exceed recommended dosage. Short-term relief of severe symptoms with the smallest possible dosage is the goal of therapy. Dosage should be taken with meals or a full glass of milk. Substitute alka capsules for tablets if dyspeptic symptoms occur. Patients should discontinue the drug and report immediately any sign of: fever, sore throat, oral lesions (symptoms of blood dyscrasia); dyspepsia, epigastric pain, symptoms of anemia, black or tarry stools or other evidence of intestinal ulceration or hemorrhage, skin reactions, significant weight gain or edema. A one-week trial period is adequate. Discontinue in the absence of a favorable response. Restrict treatment periods to one week in patients over sixty.
Indications: Rheumatoid arthritis, osteoarthritis, bursitis, acute gouty arthritis and rheumatoid spondylitis.
Contraindications: Children 14 years or less, senile patients, history or symptoms of G.I. inflammation or ulceration including severe, recurrent or persistent dyspepsia, history or presence of drug allergy; blood dyscrasias, renal, hepatic or cardiac dysfunction; hypertension; thyroid disease; systemic edema; stomatitis and salivary gland enlargement due to the drug, polymyalgia rheumatica and temporal arteritis; patients receiving other potent chemotherapeutic agents, or long-term anticoagulant therapy.
Warnings: Age, weight, dosage, duration of therapy, existance of concomitant diseases, and concurrent potent chemotherapy affect incidence of toxic reactions. Carefully instruct and observe the individual patient, especially the aging (forty years and over) who have increased susceptibility to the toxicity of the drug. Use lowest effective dosage. Weigh initially unpredictable benefits against potential risk of severe, even fatal, reactions. The disease condition itself is unaltered by the drug. Use with caution in first trimester of pregnancy and in nursing mothers. Drug may appear in cord blood and breast milk. Serious, even fatal, blood dyscrasias, including aplastic anemia, may occur suddenly despite regular hemograms, and may become manifest days or weeks after cessation of drug. Any significant change in total white count, relative decrease in granulocytes, appearance of immature forms, or fall in hematocrit should signal immediate cessation of therapy and complete hematologic investigation. Unexplained bleeding involving CNS, adrenals, and G.I. tract has occurred. The drug may potentiate action of insulin, sulfonylurea, and sulfonamide-type agents. Carefully observe patients taking these agents. Nontoxic and toxic goiters and myxedema have been reported (the drug reduces iodine uptake by the thyroid). Blurred vision can be a significant toxic symptom worthy of a complete ophthalmological examination. Swelling of ankles or face in patients under sixty may be prevented by reducing dosage. If edema occurs in patients over sixty, discontinue drug.
Precautions: The following should be accomplished at regular intervals: Careful detailed history for disease being treated and detection of earliest signs of adverse reactions, complete physical examination including check of patient's weight, complete weekly (especially for the aging) or an every two week blood check, pertinent laboratory studies. Caution patients about participating in activity requiring alertness and coordination, as driving a car, etc. Cases of leukemia have been reported in patients with a history of short- and long-term therapy. The majority of these patients were over forty. Remember that arthritic-type pains can be the presenting symptom of leukemia.
Adverse Reactions: This is a potent drug, its misuse can lead to serious results. Review detailed information before beginning therapy. Ulcerative esophagitis, acute and reactivated gastric and duodenal ulcer with perforation and hemorrhage, ulceration and perforation of large bowel, occult G.I. bleeding with anemia, gastritis, epigastric pain, hematemesis, dyspepsia, nausea, vomiting and diarrhea, abdominal distention, agranulocytosis, aplastic anemia, hemolytic anemia, anemia due to blood loss including occult G.I. bleeding, thrombocytopenia, pancytopenia, leukemia, leukopenia, bone marrow depression, sodium and chloride retention, water retention and edema, plasma dilution, respiratory alkalosis, metabolic acidosis, fatal and nonfatal hepatitis (cholestasis may or may not be prominent), petechiae, purpura without thrombocytopenia, toxic pruritus, erythema nodosum, erythema multiforme, Stevens-Johnson syndrome, Lyell's syndrome (toxic necrotizing epidermolysis), exfoliative dermatitis, serum sickness, hypersensitivity angiitis (polyarteritis), anaphylactic shock, urticaria, arthralgia, fever, rashes (all allergic reactions require prompt and permanent withdrawal of the drug), proteinuria, hematuria, oliguria, anuria, renal failure with azotemia, glomerulonephritis, acute tubular necrosis, nephrotic syndrome, bilateral renal cortical necrosis, renal stones, ureteral obstruction with uric acid crystals due to uricosuric action of drug, impaired renal function, cardiac decompensation, hypertension, pericarditis, diffuse interstitial myocarditis with muscle necrosis, perivascular granulomata, aggravation of temporal arteritis in patients with polymyalgia rheumatica, optic neuritis, blurred vision, retinal hemorrhage, toxic amblyopia, retinal detachment, hearing loss, hyperglycemia, thyroid hyperplasia, toxic goiter, association of hyperthyroidism and hypothyroidism (causal relationship not established), agitation, confusional states, lethargy; CNS reactions associated with overdosage, including convulsions, euphoria, psychosis, depression, headaches, hallucinations, giddiness, vertigo, coma, hyperventilation, insomnia; ulcerative stomatitis, salivary gland enlargement
(B)98-146-070-J (10/71)

For complete details, including dosage, please see full prescribing information.

GEIGY Pharmaceuticals
Division of CIBA-GEIGY Corporation
Ardsley, New York 10502

BU 10259

Preliminary Program
117th Annual Session

MISSOURI STATE MEDICAL ASSOCIATION

Chase-Park Plaza Hotel, St. Louis April 17-20, 1975

Thursday, April 17

11:00 AM Registration of Delegates.
1:30 PM **House of Delegates Meeting,** opening session.
3:00 PM Reference Committee Meetings.
6:30 PM Missouri State Surgical Society Executive Council Meeting.

Friday, April 18

8:00 AM Registration.
9:00 AM General Session. *National Health Insurance.*
Introduction: James C. Cope, M.D., Columbia, MSMA President.
Speakers: Top staff personnel from the Committees of the U. S. Congress who will have the responsibility of considering National Health Insurance Legislation in the 1975 Session of Congress.
10:30 AM **Intermission to view exhibits.**
10:30 AM Presiding: Jean Chapman, M.D., Cape Girardeau, President, Missouri State Allergy Association.
Participants:
Opening Remarks, Jean Chapman, M.D.
Bronchial Asthma: A Pilot Model for Diseases with Multiple Causes, Max Samter, M.D., Chicago, Ill., Professor of Medicine, Abraham Lincoln School of Medicine and Director, Institute of Allergy and Clinical Immunology, Grant Hospital.
Determination of Saliva Theophylline Concentrations in Asthmatic Children, Stephen A. Leslie, M.D., Kansas City, Fellow in Allergy and Immunology, The Children's Mercy Hospital.
Immunotherapy in Malignant Disease, Larry E. Millikan, M.D., Columbia, Associate Professor of Dermatology, University of Missouri Medical Center.
"T" Cell Deficiency (Nezaloffs)—Case Report, Donald Strominger, M.D., St. Louis, Assistant Clinical Professor of Pediatrics, Washington University School of Medicine.
The Ecology of Ragweed Pollinosis, William Solomon, M.D., Ann Arbor, Mich., Associate Professor of Internal Medicine, University of Michigan Medical School.
Sponsored by the Missouri State Allergy Association.
*11:00 AM *Nuggets of Internal Medicine.*
Moderator: Thomas F. Frawley, M.D., St. Louis.
Participants:
Proper Use of Lung Scans in Diagnosis of Pulmonary Emboli, Roger Secker-Walker, M.D., St. Louis.
Diagnosis of Upper Gastrointestinal Bleeding, Edward D. Kinsella, M.D., St. Louis.
Treatment of Osteopenia—1975, Louis Avioli, M.D., St. Louis.
Diagnosis of Acutely Inflamed Joints, William Gaunt, M.D., Columbia.
Hypertension: Treatment Guidelines, Gerhardt Muelheims, M.D., St. Louis.
Sponsored by the Missouri Society of Internal Medicine and the American College of Physicians (Missouri Region).
*11:00 AM *Common Problems in Infectious Diseases.*
Moderator: C. Terrence Dolan, M.D., North Kansas City.
Panel Discussants:
Martin C. McHenry, M.D., Cleveland, Ohio, Head, Department of Infectious Diseases, Cleveland Clinic.
C. Terrence Dolan, M.D., N. Kansas City, Department of Pathology, N. Kansas City Memorial Hospital.
Sponsored by the Missouri Society of Pathologists, Inc.
*11:00 AM *Intestinal Bypass for Morbid Obesity.*
Moderator: George L. Tucker, M.D., St. Louis.
Panel Participants:
Gene B. Starkloff, M.D., St. Louis.
Boyd E. Terry, M.D., Columbia.
Duane Q. Hagen, M.D., St. Louis.
Sponsored by the Missouri State Surgical Society.

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* Concurrent Sessions.

*11:00 AM Panel on *Acute Respiratory Failure.*

Moderator: Peter W. Kinsella, M.D., St. Louis.

Panel Participants:

Kaye Kilburn, M.D., Columbia.

Robert Senior, M.D., St. Louis.

Stephan Lefrak, M.D., St. Louis.

Sponsored by the Missouri Thoracic Society and the American College of Chest Physicians.

12:30 PM Missouri University Medical Alumni Luncheon.

12:30 PM Missouri Society of OB-GYN and American College of Obstetricians and Gynecologists Luncheon.

12:30 PM Missouri Society of Pathologists Luncheon.

12:30 PM Missouri Thoracic Society Luncheon.

* 2:00 PM Participants:

Therapeutic Approach in the Resistant Asthmatic, Hyman Chai, M.D., Denver, Colo., Director of Hospital Services, The National Asthma Center.

Rast Inhibition for Determination of Antigen Standardization, Robert J. Dockhorn, M.D., Kansas City, Chief of the Allergy-Immunology Section, The Children's Mercy Hospital.

Clinical Standardization of Allergenic Extracts, James W. Willoughby, M.D., Kansas City, Lecturer in Medicine, University of Missouri School of Medicine.

Phagocytic Function in an Atopic Population, Christopher Gifford, M.D., Kansas City, Fellow in Allergy and Immunology, The Children's Mercy Hospital.

Round Table Discussion: The Problem Allergic Patient, Max Samter, M.D., William Solomon, M.D., Hyman Chai, M.D.

Sponsored by the Missouri State Allergy Association.

* 2:00 PM *Symposium: Coronary Artery Disease—A Continuing Controversy.*

Moderator: To be announced.

Participants:

Can It Be Prevented?, Jerome D. Cohen, M.D., St. Louis, Chief, Department of Internal Medicine, St. Louis County Hospital.

The Aggressive Plan of Management, Ben McCallister, M.D., Kansas City, Associate Professor of Medicine, University of Missouri-Kansas City.

The Conservative Plan of Management, Richard Martin, M.D., Columbia, Professor of Medicine, University of Missouri-Columbia.

Sponsored by the Missouri Society of Internal Medicine and American College of Physicians (Missouri Region).

* 2:00 PM *Role of the Pediatric Nurse Practitioner in Care of Children,* Larry Kahn, M.D., St. Louis, Associate Professor, Department of Pediatrics, Washington University School of Medicine.

Panel Participants: To be announced.

Sponsored by the Missouri Chapter, American Academy of Pediatrics.

* 2:00 PM *Sexual Dysfunction,* Marcel Saghir, M.D., St. Louis.

Moderator: Richard T. Quick, M.D., St. Louis.

Sponsored by the Missouri Psychiatric Association.

* 2:00 PM *The Surgical Treatment of Breast Cancer.*

Moderator: John S. Spratt, Jr., M.D., Columbia.

Speaker: Robert Hermann, M.D., Cleveland, Ohio.

The Results of Selective, Conservative Treatment for Breast Cancer—A Ten-Year Follow-Up.

Panelist: Leslie Wise, M.D., St. Louis.

Sponsored by Missouri State Surgical Society.

3:30 PM Intermission to view exhibits.

4:00 PM House of Delegates, second session.

5:00 PM Missouri State Medical Foundation Annual Meeting.

6:00 PM Reference Committee Meetings.

6:00 PM Cocktails and Dinner: Missouri State Allergy Association.

Speaker: Stanley Hampton, M.D., Chairman of the Conjoint Socioeconomic Committee, Co-Director of Allergy Clinic, Assistant Professor of Clinical Medicine, Department of Internal Medicine, Washington University School of Medicine, St. Louis.

The Current Status of the Activities of the Conjoint Socioeconomic Committee for Allergy.

6:00 PM Cocktails and Dinner: Missouri Psychiatric Association.

Speaker: Melvin Sabshin, M.D., Medical Director, American Psychiatric Association.

Problems and Prospects in Psychiatric Education.

6:30 PM Dinner Meeting: Missouri State Surgical Society.

Speaker: Vallee L. Willman, M.D.

Trends in Surgical Education: Graduate and Postgraduate.

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* Concurrent Sessions.

Saturday, April 19

8:00 AM Registration.

*9:00 AM *Nuggets of Internal Medicine.*
Moderator: Leonard H. Brubaker, M.D., Columbia.
Participants:
Treatment of High Risk Patients with Carcinoma of the Breast, Leonard White, M.D., Columbia.
The Solution for Gallstones, James Butt, M.D., Columbia.
Headache: Nonmenstrual Cycles, James Dexter, M.D., Columbia.
Diabetes Mellitus: Two Shots a Day Keeps the Doctor Away, Ronald C. James, M.D., Columbia.
The Pathophysiological Approach to Anemia, Patrick H. Henry, M.D., Columbia.
Sponsored by the Missouri Society of Internal Medicine and the American College of Physicians (Missouri Region).

*9:00 AM *High Risk Pregnancy.*
Moderator: James P. Crane, M.D., Lindenwold, N. J.
Participants:
Antepartum Management—An Organized Approach, James Crane, M.D., Lindenwold, N. J.
Sonography, Jacques Sauvage, M.D., St. Louis, Associate Professor, OB-GYN, Washington University.
Fetal Scalp Sampling, Timothy O'Connor, M.D., St. Louis, Instructor, OB-GYN, St. Louis University.
Amniocentesis and Evaluation of Fetal Maturity, Manuel R. Comas, M.D., St. Louis, Associate Professor, OB-GYN, St. Louis University.
Discussion, followed by Question and Answer Period.
Sponsored by the American College of Obstetricians and Gynecologists.

*9:00 AM *Intra Ocular Lens Implants,* Dennis Shepard, M.D., Santa Maria, Calif.
Moderator: Anwar Shah, M.D., St. Louis.
Sponsored by the Missouri Ophthalmological Society, Inc.

*9:00 AM *Medical Uses of Acupuncture,* Robert D. Baer, M.D., Salt Lake City, Utah, Holy Cross Hospital.
Bedsores, a Preventable Complication, Shirley M. McCleur, M.D., Columbia, University of Missouri.
Improvised Mechanical Devices for the Severely Handicapped Patient Confined to Bed or Wheelchair, Otakar Machek, M.D., St. Louis.
Moderator: Franz U. Steinberg, M.D., St. Louis.
Sponsored by Physical Medicine and Rehabilitation.

*9:00 AM *Transplantation of the Kidney in Missouri.*
Moderator: William T. Newton, M.D., St. Louis.
Panelists: Gilbert Ross, Jr., M.D., Columbia.
Fred Whittier, M.D., Kansas City
Sponsored by the Missouri State Surgical Society.

10:30 AM Intermission to view exhibits.

*11:00 AM *Fiberoscopy in Diagnosis and Treatment of Cancer.*
Moderator: To be announced.
Panelists:
Rectosigmoid and Colon, Burton A. Shatz, M.D., St. Louis, Associate Professor of Medicine, Washington University School of Medicine, and Chief of Gastroenterology, Jewish Hospital of St. Louis.
Upper GI Tract and Appendages, Edward D. Kinsella, M.D., St. Louis, Clinical Associate Professor of Medicine, St. Louis University School of Medicine.
Bronchial Tract, Howard A. Andersen, M.D., Rochester, Minn., Department of Thoracic Diseases and Internal Medicine, Mayo Clinic.
Sponsored by the Missouri Division of the American Cancer Society.

*11:00 AM *Chronic Otitis Media.*
Moderator: Donald J. Joseph, M.D., Columbia.
Panel Discussants:
History and Physical Findings, Lindsay L. Pratt, M.D., St. Louis.
Radiological Findings, Joseph W. West, M.D., St. Louis.
Medical Therapy, Floyd R. Barnhill, M.D., Springfield.
Surgical Management, Michael F. Hughes, M.D., Kansas City.
Sponsored by the Missouri Ear, Nose and Throat Association, Inc.

*11:00 AM *Modern Approach to Spinal Cord Disease and Injuries,* Simon Horenstein, M.D., St. Louis.
Report on Computerized Axial Tomography in Brain Disease Diagnosis, Carol Archer, M.D., St. Louis.
Moderator: Simon Horenstein, M.D.
Sponsored by the St. Louis Neurological Sciences.

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*Concurrent Sessions.

*11:00 AM *Ambulatory Gynecology—Newer Aspects.*
Moderator: William Ott, M.D., St. Louis
Participants:
Overview and Diagnostic Uses of Laparoscopy, William Ott, M.D., St. Louis, Instructor OB-GYN, St. Louis University.
Therapeutic Uses of Laparoscopy, Ernst Friedrich, Jr., M.D., St. Louis, Associate Professor, OB-GYN, Washington University.
Colposcopy, H. Marvin Camel, M.D., St. Louis, Associate Professor, OB-GYN, Washington University.
Endometrial Sampling, Praphat Hovadhanakul, M.D., St. Louis, Assistant Professor, OB-GYN, St. Louis University.
Discussion followed by Question and Answer Period.
Sponsored by the American College of Obstetricians and Gynecologists.

*11:00 AM *PSRO in Missouri, 1975.*
Moderator: Richard V. Bradley, M.D., St. Louis.
Panelists: Paul R. Young, M.D., Columbia.
Fred D. Fowler, M.D., Kansas City.
Michael Clarke, M.D., Springfield.
Charles McGinty, M.D., Cape Girardeau.
Clement Grebel, M.D., St. Louis.
Sponsored by the Missouri State Surgical Society.

12:30 PM **MSMA General Luncheon.**
Guest Speaker: Frank J. Jirka, Jr., M.D., Member, AMA Board of Trustees.

12:30 PM **Fifty-Year Club Luncheon.**

12:30 PM Physical Medicine and Rehabilitation Luncheon.

12:30 PM St. Louis Neurological Sciences Luncheon.

12:30 PM Missouri State Society of Neurological Surgeons Luncheon.

12:30 PM Missouri Ophthalmological Society, Inc., Luncheon

12:30 PM St. Louis Gynecological Society and American College of Obstetricians and Gynecologists Luncheon.

1:30 PM *Program on Radiology.*
Moderator: John L. Bardsley, M.D., St. Louis.
Participants:
The Pediatric Vertebral Column—Structural Abnormalities, Alan Oestreich, M.D., Columbia.
A Systematic Approach to Renal Masses, G. Leland Melson, M.D., St. Louis.
Roentgen Evaluation of the Retrotracheal Space, John B. Shields, M.D., St. Louis.
Current Status of Radiological Information Systems, Gwilym S. Lodwick, M.D., Columbia.
A Comparison of Radioisotope Brain Scanning and Cerebral Computerized Axial Tomography (Which and When), Philip O. Alderson, M.D., St. Louis.
Sponsored by the Missouri Radiological Society.

• 2:30 PM *Common Skin Diseases, Management Pearls.*
Moderator: Gordon C. Sauer, M.D., Kansas City.
Panel Participants:
Norman Asel, M.D., Columbia.
Donald Fuhrman, M.D., Kansas City.
James Sisk, M.D., St. Louis.
Wilfred Wooldridge, M.D., Springfield.
(Slides of Cases will be presented and the panel will make comments appropriate to management.)
Sponsored by the Missouri Dermatological Society.

° 2:30 PM Moderator: Ben D. McCallister, M.D., Kansas City.
Speakers:
Studies on the Objective Results of the Coronary Artery Bypass Surgery Graft Patency, Coronary Blood Flow, Survival—The Cardiologist's View, Robert Frye, M.D., Rochester, Minn., Chairman, Cardiovascular Diseases, Mayo Clinic.
Studies on the Objective Results of Coronary Artery Bypass Surgery Graft Patency, Coronary Blood Flow, Survival—the Surgeon's View, Duncan A. Killen, M.D., Kansas City, Professor of Surgery, University of Missouri-Kansas City.
Sponsored by the Missouri Heart Association, Inc.

° 2:30 PM Panel Discussion on *Gynecological Cancer.*
Moderator: Yasuo Ishida, M.D.
Sponsored by the American College of Obstetricians and Gynecologists.

4:00 PM **Intermission to view exhibits.**

5:00 PM St. Louis University Medical Alumni Cocktail Party.

5:00 PM Washington University Medical Alumni Cocktail Party.

5:00 PM Missouri University Medical Alumni Cocktail Party.

6:30 PM Social Hour for Those Attending Banquet.
7:15 PM Annual Banquet in Honor of Past-Presidents.

Sunday, April 20

7:30 AM House of Delegates, breakfast and final session.

OFFICIAL DELEGATES

117th MSMA Annual Session

County	*Delegates*	*Alternates*
Andrew	J. L. Villahermosa, Savannah	Warren C. Baker, Savannah
Audrain	Benjamin N. Jolly, Mexico	Harold D. Lankford, Mexico
Barton	Thomas W. Carroll, Lamar	Herbert M. Arnold, Lamar
Boone	Hugh E. Stephenson, Jr., Columbia	Thomas W. Burns, Columbia
"	William B. See, Columbia	George J. Fuchs, Jr., Columbia
"	John T. Logue, Columbia	William C. Allen, Columbia
"	Benedict A. Moranville, Columbia	Donald A. Senhauser, Columbia
"	Kenneth K. Keown, Columbia	John S. Spratt, Jr., Columbia
"	Kenneth L. Rall, Columbia	Leroy J. Miller, Columbia
Buchanan	Allen I. Herman, St. Joseph	R. Philip Acuff, St. Joseph
"	William B. Rost, St. Joseph	Gerald E. Fox, St. Joseph
"	Donald J. Stallard, St. Joseph	Berwyn H. Moen, St. Joseph
"	Ernest E. Wadlow, St. Joseph	Gordon S. Paulson, St. Joseph
Butler-Wayne-Ripley-Carter	George H. Ladyman, Poplar Bluff	Bennie N. Till, Poplar Bluff
"	Fred Caldwell, Poplar Bluff	Robert H. Laatch, Poplar Bluff
"	Kirby L. Turner, Poplar Bluff	S. K. Reddy, Poplar Bluff
"	T. Eugene Ruff, Poplar Bluff	Barry B. White, Poplar Bluff
Callaway	James K. Ritterbusch, Fulton	Henry Durst, Fulton
Cape Girardeau	Harold B. Rapp, Cape Girardeau	Charles H. Cozean, Cape Girardeau
"	Melvin C. Kasten, Cape Girardeau	Edwin K. Burford, Cape Girardeau
"	John K. Holcomb, Cape Girardeau	J. Marshall Jung, Illmo
Chariton-Macon-Monroe-Randolph	Daniel D. Stuart, Brunswick	Rogelio L. Bautista, Moberly
"	James E. Campbell, Macon	Donald E. Eggleston, Macon
"	Floyd A. Barnett, Paris	W. D. Chute, Moberly
"	G. R. Hudson, Moberly	C. C. Cohrs, Moberly
Clay	Donald E. Kuenzi, Kansas City	Richard C. Hedges, Excelsior Springs
"	Truman B. Schertz, N. Kansas City	Donald A. Fakhoury, Kansas City
"	C. A. Stratman, Kansas City	
"	C. K. Fotopoulos, N. Kansas City	
Clinton	Paul T. Luckenbill, Plattsburg	J. H. Sweiger, Plattsburg
Cole	Robert H. Tanner, Jefferson City	Charles W. Cooper, Jefferson City
"	Mary K. McCaffree, Jefferson City	James T. Leslie, Jr., Jefferson City
"	Kenneth K. C. Siu, Jefferson City	Joseph P. Russell, Jefferson City
Cooper	George W. Winn, Boonville	
Dallas-Hickory-Polk-Dade	O. A. Griffin, Jr., Buffalo	
"	George G. Robinson, Humansville	Evelyn Griffin, Buffalo
"	Monte R. Kahler, Bolivar	Charles H. Barnett, Bolivar
"	Lee A. McNeel, Jr., Greenfield	
Dunklin	George Q. Dunmire, Kennett	John K. Legan, Kennett

County	*Delegates*	*Alternates*
Franklin-Gasconade-Warren	Samuel C. Bonney, Washington	Raymond J. Bozzo, Washington
”	George M. Workman, Hermann	Paul A. Brenner, Owensville
”	Harold F. Hoelscher, Warrenton	George B. Grim, Warrenton
Grand River		
Caldwell	Frank R. Daley, Hamilton	
Carroll	John H. Platz, Carrollton	E. Warren Allen, Carrollton
Daviess	J. Larry Dowell, Pattonsburg	
DeKalb	Fred K. Wilson, Winston	
Grundy	Albert D. Cross, Trenton	David L. Ryan, Trenton
Harrison	Watkins A. Broyles, Bethany	Merriam Gearhart, Bethany
Linn	John R. Dixon, Brookfield	Theodore George, Marceline
Livingston	Joseph A. Conrad, Chillicothe	Thomas Cofer, Chillicothe
Mercer		
Greene	Stanley S. Peterson, Springfield	David W. Brown, Springfield
”	Walter A. German, Springfield	Jay Milne, Springfield
”	Don Menchetti, Springfield	Donald Beisner, Springfield
”	Leo Wyrsch, Springfield	Charles J. Ash, Springfield
”	Henry C. Krahn, Springfield	Anita Isaac, Springfield
”	Thomas P. Sweeney, Springfield	David Spalding, Springfield
”	H. B. Ivy, Springfield	Richard Loeb, Springfield
Henry	Richard H. King, Clinton	James O. Smith, Clinton
Howard	William G. Marshall, Glasgow	F. D. Dean, Fayette
Jackson	Martin L. Crow, Kansas City	David A. Tillema, Kansas City
”	Robert C. Fairchild Shawnee Mission, Kans.	Richard E. Baska, Kansas City
”	John A. Griffith, Jr., Kansas City	Seymour J. Kranson, Independence
”	Frederick H. Hartwig Kansas City	Harry C. Wall, Kansas City
”	William D. Hoadley Kansas City	Charles P. Gauthier, Kansas City
”	Harry S. Jonas, Independence	Selbert G. Chernoff, Kansas City
”	George J. Lytton, Kansas City	Joseph A. Pinkerton, Kansas City
”	Robert M. Mathews, Kansas City	Lafe W. Bauer, Kansas City
”	Richardson K. Noback Kansas City	James W. Neumann, Kansas City
”	Thomas P. O'Farrell Kansas City	Larry G. Piepergerdes, Kansas City
”	Americo G. Ramos, Kansas City	Daniel J. Cutcliff, Kansas City
”	O. Dale Smith, Kansas City	Robert W. Doering, Kansas City
”	Walter J. Stelmach, Kansas City	Thomas J. Fritzlen, Kansas City
”	Edward J. Twin, Kansas City	Vance Link, Independence
”	S. Dwight Woods, Kansas City	Sidney Pakula, Kansas City
”	Ronald A. Youmans, Kansas City	John A. Sheahon, Kansas City
”	Alfred D. Biggs, Jr., Kansas City	Herbert Waxman, Kansas City
”	Calvin E. Engelmann Kansas City	George P. Williams, Kansas City
”	Braham J. Geha, Kansas City	
”	R. Stacy Long, Kansas City	
”	Mark D. Ost, Kansas City	
”	Milton B. Ozar, Kansas City	
”	John M. Singleton, III Kansas City	
”	Fred D. Fowler, Kansas City	
”	R. Don Blim, Kansas City	
”	Edwin E. MacGee, Kansas City	
”	Warren F. Wilhelm, Kansas City	
”	T. J. Bryant, Kansas City	

County	*Delegates*	*Alternates*
Jasper	John R. Esther, Joplin	Charles S. Davis, Joplin
”	Marvin A. Singleton, Joplin	Joe Longenecker, Joplin
”	Robert L. Willcoxon, Joplin	Edward Grimm, Joplin
Jefferson	Vicente D. Deles, Crystal City	J. Logan Mayfield, Crystal City
Johnson	T. Reed Maxson, Warrensburg	Charles M. Lederer, Warrensburg
Lafayette-Ray	Robert R. Pavlu, Waverly	William C. LaHue, Lexington
”	George K. Davault, Richmond	Thomas B. Cook, Richmond
Lewis-Clark-Scotland	Landis Y. Davis, Canton	
Marion-Ralls-Shelby	Stanley G. Hall, Hannibal	Carl R. Kruse, Palmyra
”	J. Russell Comer, Hannibal	Edward M. Plowman, Hannibal
”	Charles L. Lichty, Shelbina	Phillip B. Foreman, Hannibal
Mid-Missouri		
Crawford	Frank A. Elders, Jr., Cuba	Albert R. Baumann, Steelville
Dent	B. J. Bass, Salem	Roy E. Mitchell, Salem
Laclede	Rae W. Froelich, Lebanon	Howard W. Carrington, Lebanon
Maries	Bernard Draper, Rolla	Eugene F. White, Rolla
Phelps	Earl E. Feind, Rolla	Barbara E. Russell, Rolla
Pulaski	Clyde S. Miller, Waynesville	
Miller	Carl T. Buehler, Jr., Eldon	Edward O. Shelton, Eldon
Mineral Area		
St. Francois	Charles W. Chastain, Farmington	Alvan G. Karraker, Farmington
Iron	Robert F. Dettmer, Ironton	Marvin C. Menne, Ironton
Madison	A. R. Rao, Fredericktown	Robert A. Huckstep, Farmington
Washington	David Wilson, Potosi	Carlos J. Borromeo, Rivermines
Reynolds	Charles H. Appleberry Rivermines	Jack Mullen, Bonne Terre
Bollinger	Norma D. Farmer, Farmington	Jay F. Tuttle, Farmington
Moniteau	Richard B. Fulks, California	Kenyon S. Latham, California
Montgomery	Samuel J. Byland, Wellsville	
Morgan	J. Loren Washburn, Versailles	Ruth Kauffman, Versailles
North Central		
Adair	Francis Tarvydas, Edina	
Knox	Milton T. English, Kirksville	
Schuyler		
Sullivan		
Putnam		
Northwest		
Nodaway		
Holt		
Atchison		
Gentry		
Worth		
Ozarks		
Lawrence	Kenneth Glover, Mt. Vernon	William P. Hamilton, Aurora
Stone	Fred L. Wommack, Crane	
Barry	R. R. Donley, Monett	F. R. Esparrago, Monett
Newton	Paul Anderson, Neosho	Richard Betz, Neosho
Christian		
McDonald	George Blankenship, Neosho	Arthur J. Graves, Mt. Vernon
Taney	Roy Gillispie, Branson	
Pemiscot	Alan S. Gubin, Caruthersville	Oliver W. Cook, Caruthersville
Perry-Ste. Genevieve	Job B. Pontillas, Perryville	Joseph F. Lutkewitte, Ste. Genevieve
”	Alfred E. McDermott, Perryville	Martin L. Key, Ste. Genevieve

County	*Delegates*	*Alternates*
Pettis	J. E. Block, Sedalia	A. J. Campbell, Sedalia
Pike	Charles H. Lewellen, Louisiana	Glenn E. Miles, Louisiana
Platte	Paul C. Vescovo, Kansas City	S. Lloyd Allen, Kansas City
St. Charles-Lincoln	Paul H. Rother, St. Charles	Gary R. Vart, St. Charles
"	John C. Soucy, St. Charles	James P. Felder, St. Charles
"	Edward O. Damron, Elsberry	Joseph C. Creech, Troy
St. Louis City	L. B. Anglo, St. Louis	William E. Allen, Jr., St. Louis
"	William C. Banton, St. Louis	Walter F. Ballinger, St. Louis
"	Donald T. Behrens, St. Louis	Arthur E. Baue, St. Louis
"	Ralph L. Biddy, St. Louis	Walter Baumgarten, Jr., St. Louis
"	Morton A. Binder, St. Louis	Leonard Berg, St. Louis
"	Albert G. Boldizar, St. Louis	Bryce H. Bondurant, St. Louis
"	Leslie F. Bond, St. Louis	George A. Brennan, St. Louis
"	Richard V. Bradley, St. Louis	George Bohigian, St. Louis
"	Robert Brookes, St. Louis	Armand E. Brodeur, St. Louis
"	Thomas J. Cooper, St. Louis	Kenneth Bruns, St. Louis
"	Richard H. Fallon, St. Louis	R. William Burmeister, St. Louis
"	Robert H. Felix, St. Louis	Peter A. Diemer, St. Louis
"	Daniel M. Fraser, St. Louis	Robert K. Dorton, St. Louis
"	Raymond O. Frederick, St. Louis	Theodore J. Dubuque, Jr., St. Louis
"	August W. Geise, Jr., St. Louis	Murray E. Finn, St. Louis
"	Jerome J. Gilden, St. Louis	Joseph C. Edwards, St. Louis
"	Charles Gulick, St. Louis	Thomas F. Frawley, St. Louis
"	James N. Heins, St. Louis	Lance Gerowin, St. Louis
"	Donald R. Judd, St. Louis	John H. Gladney, St. Louis
"	Robert W. Kelley, St. Louis	Robert S. Goell, St. Louis
"	John J. Kelly, St. Louis	James Y. Griggs, St. Louis
"	Francis X. Lieb, St. Louis	George L. Hawkins, St. Louis
"	J. Otto Lottes, St. Louis	Eugene G. Hamilton, St. Louis
"	Philip S. Luedde, St. Louis	James W. Haynes, St. Louis
"	Robert R. MacDonald, St. Louis	Alan S. Holtz, St. Louis
"	Paul F. Max, St. Louis	George C. Kaiser, St. Louis
"	Robert N. Miller, St. Louis	John H. Kendig, St. Louis
"	Jack Kayes, St. Louis	Edward D. Kinsella, St. Louis
"	Laurence Lawton, St. Louis	Norman P. Knowlton, St. Louis
"	Leo LeBlanc, St. Louis	David M. Lieberman, St. Louis
"	Marshall B. Conrad, St. Louis	James N. Macnish, St. Louis
"	William Stoneman, III, St. Louis	Theodore M. Meiners, St. Louis
"	Michael G. Murphy, St. Louis	William F. Melick, St. Louis
"	Charles H. Nicolai, St. Louis	Mary E. Morris, St. Louis
"	Lawrence O'Neal, St. Louis	Leo V. Mulligan, St. Louis
"	Theodore Paletta, St. Louis	Henry O. Onken, St. Louis
"	Lily A. Palmer-Hanes, St. Louis	James F. Nickel, St. Louis
"	F. E. Pennington, St. Louis	Henry E. Oppenheimer, St. Louis
"	Harry A. Reich, St. Louis	Robert C. Packman, St. Louis
"	Hubert A. Ritter, St. Louis	William E. Powers, St. Louis
"	Percival Salanga, St. Louis	David M. Reisler, St. Louis
"	John S. Sciortino, St. Louis	Daniel L. Sexton, St. Louis
"	Charles S. Sherwin, St. Louis	Donald G. Spalding, St. Louis
"	A. J. Signorelli, St. Louis	Robert Thomasson, St. Louis
"	James M. Stokes, St. Louis	Pablo C. deUngria, St. Louis
"	Clarence M. Turner, St. Louis	Ronald P. Wilbois, St. Louis
"	Hugh R. Waters, St. Louis	R. Dean Wochner, St. Louis

County	*Delegates*	*Alternates*
"	Carol F. Williams, St. Louis	Richard W. Yore, St. Louis
"	George Zografakis, St. Louis	
St. Louis County	C. Read Boles, St. Louis	David M. Berwald, St. Louis
"	Rudolph E. Catanzaro, St. Louis	G. Robert Bowles, St. Louis
"	Edwin J. Cunningham, St. Louis	Joseph E. Cacioppo, St. Louis
"	Jules H. Kopp, St. Louis	Harold J. Freiheit, St. Louis
"	John M. Laird, Jr., St. Louis	Santiago Y. Hallazgo, St. Louis
"	Robert A. Mayer, St. Louis	Falls B. Hershey, St. Louis
"	Jerry N. Middleton, St. Louis	Gerald J. Hobson, St. Louis
"	Vernon H. Balster, St. Louis	Herluf G. Lund, St. Louis
"	Robert B. Deitchman, St. Louis	Morris D. Marcus, St. Louis
"	Allen P. Klippel, St. Louis	David L. Ohlms, St. Louis
"	Robert J. Mueller, St. Louis	William L. Tomlinson, St. Louis
"	James R. Nakada, St. Louis	Frank J. Valach, St. Louis
"	Frederick D. Peterson, St. Louis	Noel F. Weyerich, St. Louis
"	Rudy Ruhling, St. Louis	Miles C. Whitener, St. Louis
"	Melvin M. Schwartz, St. Louis	Ray J. Wolff, St. Louis
"	James C. Sisk, St. Louis	
Saline	C. A. McBurney, Slater	E. Lee McCorkle, Marshall
SEMO		
Stoddard	Edwin J. Masters, Advance	John H. Askew, Sikeston
New Madrid	John P. Sargent, Sikeston	William C. Critchlow, Sikeston
Mississippi	Gregario Rodriguez, Charleston	Wilbur Davis, Charleston
Scott	William C. Shell, Sikeston	Max A. Heeb, Sikeston
South Central		
Wright	James A. Hasek Mountain Grove	O. Martin Hasek, Mountain Grove
Texas	Joe A. Wall, Houston	Joe L. Spears, Cabool
Howell	Marvin L. Fowler, West Plains	W. Thomas Morgan, Jr., West Plains
Oregon	Ambrose T. Walker, Thayer	
Douglas	Rollin H. Smith, West Plains	Amos L. Coffee Willow Springs
Ozark	Jack N. Wiles, West Plains	C. Franklin Smith, Willow Springs
Webster	T. M. Macdonnell, Marshfield	John Patterson, Marshfield
West Central		
Bates	William W. Haynie, Butler	Thomas L. Huffman, Butler
Cass	Edward S. Jones, Harrisonville	Alfred W. Eklund, Pleasant Hill
Cedar	R. L. Magee, El Dorado Springs	H. V. Langeluttig, Jr., El Dorado Springs
St. Clair	Glen H. Reed, Appleton City	Robert H. Brownsberger, Appleton City
Vernon	R. John Torontow, Nevada	R. B. Wray, Nevada

Past Presidents—Delegates-at-Large

James R. McVay, Kansas City
Robert Mueller, St. Louis
Guy N. Magness, University City
H. E. Petersen, St. Joseph
Victor B. Buhler, Kansas City
Ralph Perry, Kansas City
Kenneth C. Hollweg, Kansas City
Leonard T. Furlow, Crystal River, Fla.
Paul R. Whitener, St. Ann
Byron M. Stuart, Boonville
Hector W. Benoit, Jr., Kansas City
David N. Kerr, St. Louis
Doyle C. McCraw, Bolivar
Joseph L. Fisher, St. Joseph
Gerald L. Miller, Kansas City
Walter T. Gunn, St. Louis
E. A. Stricker, St. James

Student Delegates-at-Large

University of Missouri-Columbia
- Mr. Michael Fredrich
- Mr. Dennis Nicks

University of Missouri-Kansas City
- Mr. Mark C. Kasten
- Mr. Jerry M. Alstott

St. Louis University
- Mr. Thomas E. Miles, Jr.
- Mr. Joseph B. Jones

Washington University
- Mr. Lyle Koen
- Mr. Stuart Myers

COMMERCIAL EXHIBITORS LIST

For the 117th Annual Session

Booth	Exhibitors
17	C. W. Alban & Company, Inc. St. Louis
25	American Medical Facilities Corporation Hazelwood
3	Blue Cross—Blue Shield St. Louis—Kansas City
13	Boehringer Ingelheim Ltd. Elmsford, N. Y.
15	Bristol Laboratories Syracuse, N. Y.
20	The Central Pharmacal Company Seymour, Ind.
2	Clinical Laboratories of St. Louis, Inc. Creve Coeur
44	Coca-Cola USA Chicago, Ill.
12	Data Service Agency Maryland Heights
16	Electronic Communications Ltd. St. Louis
34	The Emko Company St. Louis
10	Encyclopaedia Britannica Chicago, Ill.
19	Fisons Corporation Bedford, Mass.
30	Forrest T. Jones & Company Kansas City
32	General American Life Insurance Company St. Louis
8	Health Care Foundation of Missouri/PSRO Support Center Jefferson City
28	Homemakers Upjohn St. Louis
42	The Key Company St. Louis
21	Mallinckrodt, Inc. Hazelwood
43	Marion Laboratories, Inc. Kansas City
1	Mead Johnson Laboratories Evansville, Ind.
4	The Medical Protective Company Fort Wayne, Ind.
18	Meyer Laboratories, Inc. Fort Lauderdale, Fla.
14	Missouri Seven-Up Bottlers St. Louis
35	Munns Medical Supply Company, Inc. Topeka, Kan.
23	Organon Inc. West Orange, N. J.
27	Pfizer Laboratories, Inc. Chicago, Ill.
7	Professional Research Inc. Los Angeles, Calif.
24	Ree X-Ray Shawnee, Kan.
36	Rowell Laboratories, Inc. Baudette, Minn.
38	Sandoz Pharmaceuticals East Hanover, N. J.
26	Searle Laboratories Chicago, Ill.
9	Southern Medical Association Birmingham, Ala.
39	Stuart Pharmaceuticals Wilmington, Del.
11	Tab Products Company St. Louis
41	United Medical Equipment Company Kansas City
37	The Upjohn Company Kalamazoo, Mich.
33	Vita Mix Corporation Cleveland, Ohio
40	Wampole Laboratories Stamford, Conn.

In lieu of Exhibits, the following firms made cash donations to assist in the sponsorship of Scientific Sessions:

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April 17-20, 1975 Chase-Park Plaza Hotel St. Louis

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Pectin	142.8 mg
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Atropine sulfate	0.0194 mg.
Hyoscine hydrobromide	0.0065 mg.
Powdered opium, USP	24.0 mg.
(equivalent to paregoric 6 ml.) (warning may be habit forming)	
Sodium benzoate (preservative)	60.0 mg
Alcohol, 5%	

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Each 5 cc. contains:

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Codeine phosphate	10.0 mg.
(warning: may be habit forming)	
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Non-narcotic for 6-8 hr. cough control

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Glyceryl guaiacolate	100 mg.
Phenylephrine hydrochloride	10 mg.
Alcohol, 1.4%	

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Comprehensive decongestant action helps control cough and clear stuffy nose and sinuses. Non-narcotic.

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Phenylpropanolamine hydrochloride	12.5 mg.
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ROBITUSSIN-DM®	●	●	●		●
ROBITUSSIN-PE®	●			●	●
ROBITUSSIN®-CF	●	●		●	●
COUGH CALMERS®	■	■	■		■

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Must vasodilators and therapy for other diseases come into conflict?

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The cerebral or peripheral vascular disease patient often has coexisting disease[1] which calls for another drug along with his vasodilator. It may be a hypoglycemic, miotic, antihypertensive, diuretic, anticoagulant, corticosteroid, or coronary vasodilator.

Vasodilan is not incompatible with any of these drugs—no treatment conflict has been reported. And, unlike other vasodilators, Vasodilan has not been reported to affect carbohydrate metabolism, liver function, or intraocular pressure—or to complicate treatment of diabetes, hypertension, peptic ulcer, glaucoma, or liver disease.

In fact, there are no known contraindications to the use of Vasodilan in recommended oral doses, other than that it should not be given in the presence of frank arterial bleeding or immediately postpartum.

Indications: Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows:

Possibly Effective:

1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.
3. Threatened abortion.

Final classification of the less-than-effective indications requires further investigation.

Composition: Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg.

Dosage and Administration: 10 to 20 mg. three or four times daily.

Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

Adverse Reactions: On rare occasions, oral administration of the drug has been associated in time with the occurrence of severe rash. When rash appears, the drug should be discontinued. Occasional overdosage effects such as transient palpitation or dizziness are usually controlled by reducing the dose.

Supplied: Tablets, 10 mg.—bottles of 100, 1000, 5000 and Unit Dose; 20 mg.—bottles of 100, 500 and Unit Dose.

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[1] Gertler, M. M., et al.: Geriatrics *25*:134-148 (May) 1970.

The patient with gastritis:

another type for TYLENOL® analgesic tablets

When the gastritis patient has a condition requiring an analgesic, a new problem arises. Aspirin's irritating effect on the gastric mucosa is well documented.[1-3]

TYLENOL analgesic tablets, on the other hand, are unlikely to cause local irritation,[2,3] which is why they are preferred in the patient subject to gastritis.

This is only one of several 'types for TYLENOL' analgesic tablets — that is, patients who should avoid aspirin. Considering *all* of them, wouldn't it provide added safety (as well as added convenience) to recommend TYLENOL tablets routinely for simple analgesia?

References: 1. Muir, A., and Cossar, I. A.: Brit. Med. J. *2*:7-12 (July 2) 1955. **2.** Vickers, F.N.: Gastroint. Endosc. *14*:94-99 (Nov.) 1967. **3.** Roth, J.L.A.: Med. Clin. North Amer. *41*:1517-1537 (Nov.) 1957.

Precautions and Adverse Reactions: If a rare sensitivity reaction occurs, the drug should be stopped. Acetaminophen has rarely been found to produce any side effects.

Supplied: Tablets, 325 mg.
For Children:
Elixir, 120 mg./5cc. (alcohol 7%).
Drops, 60 mg./0.6cc. (alcohol 7%).
Chewable Tablets, 120 mg.

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Safer than aspirin, yet just as effective for relief of pain and fever

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acetaminophen tablets

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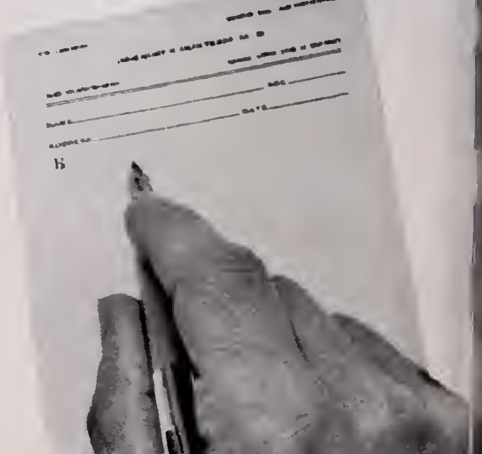


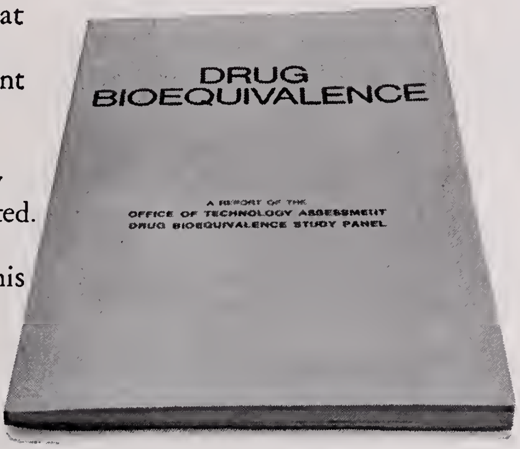
he weight of scientific opinion:

If the pharmacist substituted a emically equivalent drug for the e you have specified for your tient—could you be certain of that oduct's safety and effectiveness nply because the chemical content is the same?

Definitely not, unless bio- uivalence tests and other quality surance checks had been conducted. e pharmaceutical industry and ny scientists have maintained this sition for years, but others have estioned it. Now the Office of chnology Assessment of the ngress of the United States has ported on the issue in its Drug equivalence Study.*

Here are a few definitive state- nts in the O.T.A. report:

"...the problem of bioinequiva- cy in chemically equivalent prod- s is a real one. Since the studies in ich lack of bioequivalence was nonstrated involved marketed ducts that met current compen- l standards, these documented in- nces constitute unequivocal dence that neither the present ndards for testing the finished duct nor the specifications for terials, manufacturing process, l controls are adequate to ensure that ostensibly equivalent drug products are, in fact, equivalent in bioavailability.



DRUG BIOEQUIVALENCE

A REPORT OF THE OFFICE OF TECHNOLOGY ASSESSMENT DRUG BIOEQUIVALENCE STUDY PANEL

"While these therapeutic failures resulting from problems of bioavailability were recognized and well documented, it is entirely possible that other therapeutic failures and/or instances of toxicity that had a similar basis have escaped attention."

The Pharmaceutical Manufacturers Association supports federal legislative amendments that would require manufacturers of duplicate prescription pharmaceutical products, subject to new drug procedures, to document:

(a) chemical equivalence; and

(b) biological equivalence, where bioavailability test methods have been validated as a reliable means of assuring clinical equivalence; or

(c) where such validation is not possible, therapeutic equivalence.

In addition, the PMA supports federal legislation that would require certification of all manufacturers of prescription products before they could start in business, annual inspections and certification thereafter, and strict adherence to FDA regulations on good manufacturing practices.

The overall quality of the United States drug supply is excellent. But only a total quality assurance program, envisaged in these and other policy positions adopted by the PMA Board of Directors in 1974, can bring about acceptable levels of performance by all prescription drug manufacturers and thereby assure the integrity of your prescription...

P·M·A

Pharmaceutical Manufacturers
Association
1155 Fifteenth Street, N.W.
Washington, D.C. 20005

*Copies of the complete report on Drug Bioequivalence may be obtained from the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402.

rotecting the ntegrity of our prescription

WASHINGTON

The 94th Congress, which numbers within its ranks the largest group of Democratic freshmen representatives to have crossed the Potomac in a generation, has quickly proved that it has a will of its own and a flagrant disregard for the tradition of seniority.

A successful "freshman revolt" within the House Democratic caucus has toppled a number of "good-old-boys" from important committee chairmanships and dealt a stinging blow to the half-century old seniority system.

A less dramatic revolution, but just as significant, has quietly occurred in the Senate. Sen. Edward Kennedy (D-Mass.), after mustering a liberal coalition in his party's Steering Committee, handed out a beating to Democratic conservatives with respect to committee assignments.

But what legislative inklings this tumultous reorganization of the Congress holds for medicine is still far from clear.

Saddled with grave economic problems, President Ford stated unequivocally that his Administration will not introduce a national health insurance measure (NHI) in the first session of this Congress. Making it painfully clear in his State of the Union message that the Congress also is saddled with grave economic problems, the President also said that he would veto any approved new spending programs other than those concerned with energy.

The President's stand would seem to make it difficult indeed for Democratic liberals to get a NHI bill enacted this year, despite the enormous pressures from Labor that some of them feel.

On the other side of the picture, however, House Speaker Carl Albert (D-Okla.), in his party's formal reply to the President's State of the Union message, urged the President to reconsider his apparent threat to veto NHI this year. Albert said NHI merits high priority.

Other top members of the Democratic leadership in both houses have gone on record as favoring NHI this year, including Al Ullman (D.-Ore.) who has replaced Wilbur Mills as Chairman of the House Ways and Means Committee.

During the organization of the 94th Congress, the House Ways and Means Committee was e panded from 25 to 37 members—largely throug the addition of liberals—and for the first time su committees were established, four in number. U der the "two-to-one-plus-one" formula governi party representation on committees, this mea that Ways and Means now consists of 25 Dem crats and 12 Republicans.

Chairman of the new Ways and Means Subco mittee on Health is Rep. Dan Rostenkows (D-Ill.). Apparently determined to make a na for himself in the health field, the Chicago Dem crat has declared, "I see my role not as a propone of an individual point of view, but rather as that a consensus-builder—one who will try to resolve t differences that presently block the passage of t landmark program."

Rostenkowski said his 13-member panel w start work on health legislation immediately follo ing Ways and Means' deliberations on the Pre dent's Emergency Energy and Tax message.

"Although regular meetings of my committ won't begin until the early spring," he said, "I ho that the other committee members will review t considerable materials that are now available this subject in order that in the spring we can b gin in earnest.

"At the present time, more than $100 billion spent annually on the health care of the Americ people. Thus, any legislation that seeks to signi cantly alter both the financing and the delivery that health care will have to be developed with acute sensitivity of the many diverse problems volved. Equally as important in changing the pr ent system of health care, we must also be c cerned with the 4.4 million Americans who are e ployed in this, the nation's third largest industr

Shortly after making this statement, Represen tive Rostenkowski announced the formation of Advisory Panel of National Health Insurance— group from whom the subcommittee can draw pert information and advice for use in its work national health insurance."

The subcommittee chairman's statement c tinued. "The passage on national health insura

(Continued on page 148)

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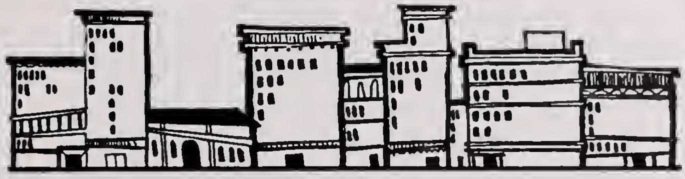

NIVERSITY OF MISSOURI-KANSAS CITY

The Robert Wood Johnson Foundation has made $900,000 award to the School of Medicine for evelopment of a primary care residency program. hrough this program, residents will be trained in ternal medicine with emphasis on comprehensive ntinuing care to a specified group of patients. he residents also will have major teaching re- onsibilities and will be related to the Docent nits in the medical school.

The major portion of the training will be at the uman Medical Center. Three months will be ent each year at Children's Mercy Hospital as ell as rotations in Emergency Medicine and Office ynecology.

The primary-care medicine program will be one two alternative pathways for residents entering e Kansas City General Hospital-Truman Medical nter residency in Internal Medicine.

An award of $1,500 per year for ten years has en made by the Missouri Division of the Ameri- n Cancer Society to the School of Medicine. This ard is to be used for a *Visiting Docentship in cology,* to be named in the memory of *James J. orach,* former executive vice-president of the issouri Division. This is the first financial award made by the American Cancer Society to the new School of Medicine.

Dr. Malcolm C. Todd, President of the AMA, visited the School of Medicine on January 29. After receiving a briefing by *Dean Richardson K. Noback,* Dr. Todd toured one of the Docent units in the new medical school building.

On January 30, the Council on Selection of the School of Medicine held a one-day retreat to review the history of the development of the selection philosophy at UMKC and to discuss psycho-social aspects of selection. Particular attention was paid to selection of qualified applicants who would be expected to practice in areas of Missouri that are presently underserved in health care.

During the last week in January, *Dr. Franz Ingelfinger,* editor of the *New England Journal of Medicine,* was a Visiting Docent. While here, Dr. Ingelfinger participated in docent unit activities on several of the units. He also gave an address on "The Role of the New England Journal of Medical Education in Continuing Education" at the University Hour on January 31.

ST. LOUIS UNIVERSITY

A conference to evaluate and restructure the St. Louis University undergraduate Medical Record

Dean Richardson K. Noback *(left)* welcomes Dr. Malcolm Todd, President of the American Medical Association, o visited the University of Missouri-Kansas City School Medicine on January 29.

Dr. George E. Thoma, vice-president of St. Louis University Medical Center *(far left),* welcomes Dr. Lawrence L. Weed to conference to evaluate and restructure the St. Louis University School of Nursing and Allied Health Professions Medical Record Administration Curriculum. Mrs. Shirley Perrin was chairman of the program.

Administration curriculum to meet the needs of the next decade was held in St. Louis on January 30-31. The innovative conference was planned by *Mrs. Shirley Perrin,* chairman of the Department of Medical Record Administration at the St. Louis University School of Nursing and Allied Health Professions, and *Dr. George E. Thoma,* vice-president for the Medical Center. Dr. Thoma said the results of the conference would have effect upon the entire health care system.

Distinguished leaders in health care who spoke included *Dr. Lawrence L. Weed,* professor of medicine and community medicine and director of PROMIS (problem oriented medical information systems laboratory) at the University of Vermont College of Medicine.

Others were *Dr. E. R. Gabrieli,* director, Clinical Information Center, State University of New York at Buffalo, "Computer Technology and the Medical Record Administrator"; *Rita M. Finnegan,* R.R.A. Ph.B., president-elect of the American Medical Record Association and director of Curriculum in Medical Record Administration, University of Illinois at the Medical Center, "Profile of Medical Record Administration Students—Prerequisites for the Professional Program"; *Dr. George E. Gantner, Jr.,* chairman, subcommittee on forensic pathology; *Dr. Raymond W. Freese,* professor and chairman, Department of Mathematics, St. Louis University and *Mr. Thomas K. Vogler,* director, Data Processing, St. Mary's Health Center, St. Louis, who participated in a panel on "Computer Technology and the Medical Record Administrator."

Dr. J. Warren Perry, dean, School of Health Professions, State University of New York at Buffalo, gave a summation of the program evaluation. As a result of the conference, the Medical Record Administration Curriculum at St. Louis University will be strengthened. Copies of the proceedings will be available in two or three months.

Dr. Peter G. Danis, clinical professor of pediatrics at St. Louis University, was the recipient of the "Health Care Leadership Award" presented by the Metropolitan Hospital Association of St. Louis on January 31. Dr. Danis created and planned the development of Cardinal Glennon Memorial Hospital for Children.

The "Health Care Leadership Award" is given annually by the Metropolitan Hospital Association to honor and recognize outstanding leadership and accomplishment in the health care field. In conjunction with Dr. D. Elliott O'Reilly, professor and chairman of orthopedic surgery at the School of Medicine, Dr. Danis helped organize the Cerebral Palsy Center at Firmin Desloge Hospital and, late at Glennon Hospital. He is responsible for establishing the Health Care program for Catholic Charities in St. Louis and served as their first pediatr cian. He was the co-founder and first president c Our Lady of Grace Center for Emotionally Di turbed Children in St. Louis. Dr. Danis is in privat practice.

WASHINGTON UNIVERSITY

Teresa J. Vietti, M.D., professor of pediatrics an associate professor of pediatrics in radiology, ha received $350,310 to continue research on canc diseases in children. She obtained the three-yea award from the National Cancer Institute. As member of the Southwest Oncology Group (a r search cooperative with members throughout th country), she is the principal investigator in th study.

In the last 15 years, a much broader program fo the treatment of malignant diseases in children ha evolved in the Washington University study. involves not only chemotherapists, but also th radiation therapists, pathologists and surgeons. Th researchers utilize new and effective treatme regimens which have been developed in the labor tory and, then, apply these to afflicted childre Because of this combined effort, significant a complishments have been made on tumor diseas

Research on Wilms' (kidney) tumor has pr duced the most outstanding results with a 90% cu rate for children with a localized tumor and a 5 success for children with disseminated diseas Strides also have been made in the treatment acute leukemia. "The median duration of surviv in children (with leukemia) used to be nine mont to a year," Dr. Vietti said. "With new metho survival now may exceed five years. And hopefull during this time a cure will be developed."

Patients with Ewing's sarcoma and osteosarco (two bone tumors) had the cure rate of 10% to 1 15 years ago. Although accurate statistics are n yet available, investigators expect that through t use of chemotherapy, survival will exceed 50%.

Other participants in the study are *A. H. Rag* M.D., *Vita J. Land,* M.D. and *Harold Zarkows* M.D., assistant professors of pediatrics; *Carlos Perez,* M.D., professor of radiology; *John M. K sane,* M.D., professor of pathology and of patholo in pediatrics; *Jessie L. Ternberg,* M.D., professor surgery and associate professor of surgery in pe atrics; *Lily A. Palmer-Hanes,* M.D. and *William Mill, Jr.,* M.D., assistant professor of radiology.

The researchers hope to establish additional eatment regimens for the other malignant diseases childhood as well as to increase the effectiveness those already used.

NIVERSITY OF MISSOURI-COLUMBIA

Dr. James Dexter, chairman of the Admissions ommittee of the School of Medicine, reports that e committee has completed its interviews for the ntering class for next August. Twelve students ac- pted under the Early Decision Plan and 98 others ve been offered places in the total class of 110.

Dr. Donald A. Senhauser, who has been a mem- r of the faculty since July 1, 1963, has been cho- n as chairman of the Department of Pathology at c Ohio State University. He will take over his new ities on July 1.

Dr. Senhauser has served as director of the Edu- tional Resources Group and director of the Mul- lisciplinary Teaching Laboratories since they were tablished in 1968-1969. He also has been chairman the Medical School's education (curriculum) mmittee and director of the hematology labora- ries and blood bank. Medical students awarded m the Golden Apple Award as the best pre-clin- l instructor in 1965-1966.

Revisions are being made in the Medical Colleges lmissions Test. *Dr. Jack Colwill*, associate dean of e School of Medicine, has been assigned to work a plan for developing noncognitive measures for e in the admissions assessment. He was appointed the AAMC's Committee on Admissions, of which is a member.

The appointment was reported in a recent news- ter from the Association of American Medical olleges. After conferring with a number of groups, . Colwill recommended that a letter of inquiry sent to appropriate experts/organizations seek- g suggestions for instruments that exist or can be sily adapted or quickly developed for the assess- ent of eight areas that are considered important. ey are (1) concern for human and societal eds; (2) ethical behavior; (3) interprofessional ationships; (4) coping capabilities; (5) sensitiv- to interpersonal relations; (6) decision-making lls; (7) staying power—physical and motivation- (8) orientation toward lifelong learning.

Dr. Colwill said that the MCAT test is revised riodically and that there will be some changes ade in 1976.

The new test will incorporate measures of both gnitive and noncognitive attributes of the stu- nts seeking admission to the nation's medical hools.

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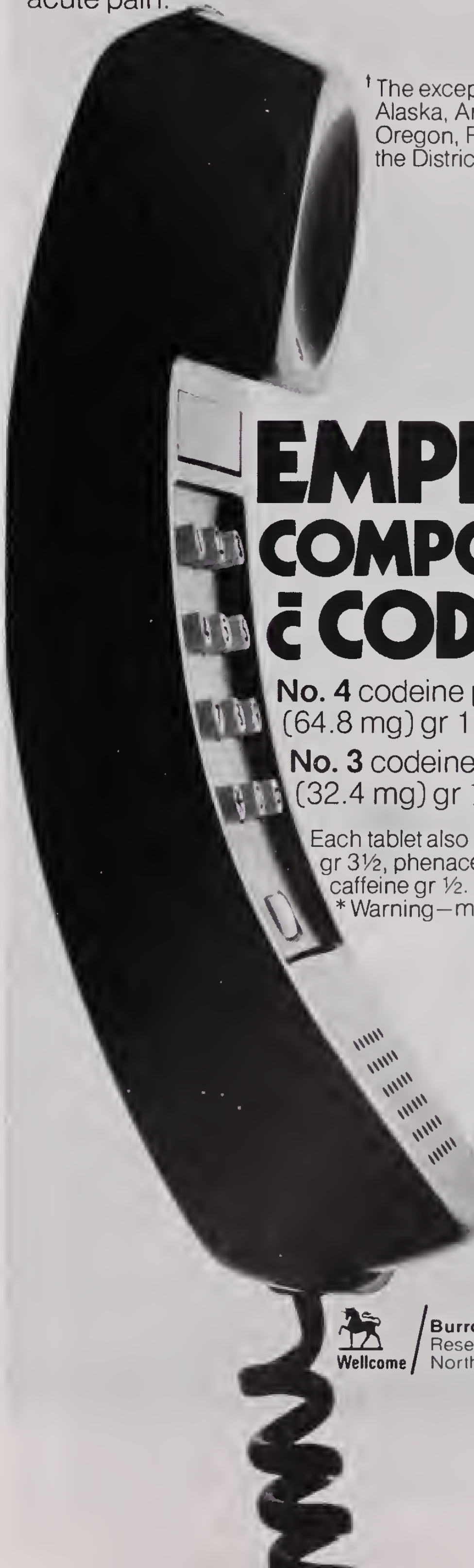

† The exceptions:
Alaska, Arizona, Maine, Oregon, Rhode Island, and the District of Columbia.

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* Warning—may be habit-forming.

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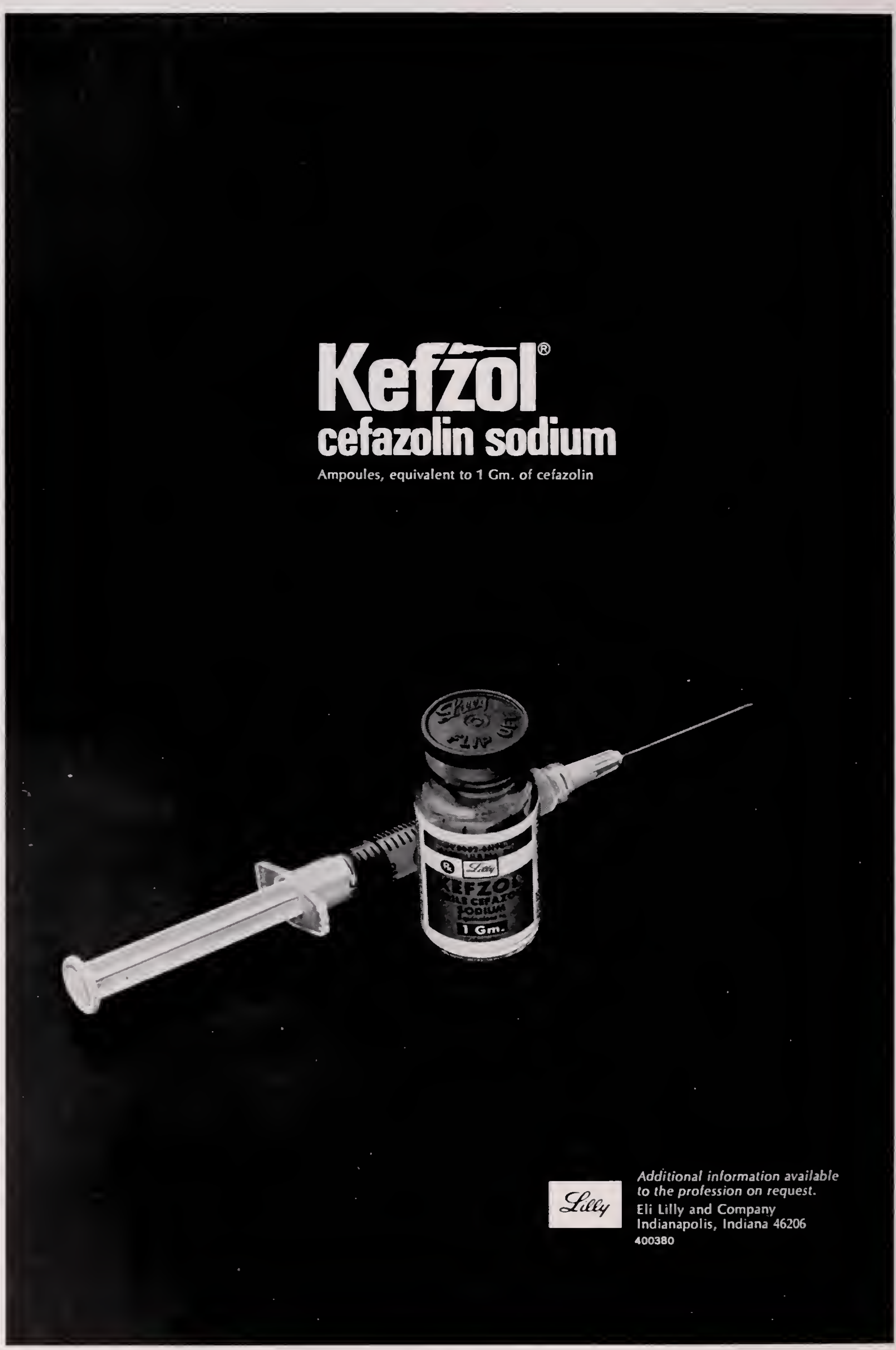
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Volume 72, Number 3—March, 1975

Missouri Medicine

JOURNAL OF THE MISSOURI STATE MEDICAL ASSOCIATION

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CALVIN WOODRUFF, M.D. *and* **GIULIO J. BARBERO, M.D.,** *Columbia*

he Challenges of Cystic Fibrosis

ystic fibrosis (CF) is a generalized disorder of e exocrine glands inherited as a recessive genetic it. The disease was more fully described as a ecific entity in 1939 with a pathology of dilated icts and fibrotic changes in the pancreas and pious secretory intraluminal obstruction of the onchial tree.[1, 2] The symptoms predominately inlve the gastrointestinal tract as more frequent, ilky, malformed and malodorous stools and the spiratory system as cough, wheezing and signs chronic respiratory obstruction. In certain ininces, only one of these two systems will have inifest symptoms and signs. An increased conntration of sodium and chloride in the sweat was scovered in 1953.[3] The elevated salt concentration the sweat has proven to be a reliable diagnostic ol to confirm the presence of the disease.

CF is one of the most common genetic diseases the white race with a frequency of approxiitely one out of 2,000 live births and a gene quency of the heterozygous state about one in of the total population. The specific mechanisms iereby the genetic abnormality produces the thologic changes is not known. The mucous cretory glands, primarily in the tracheobronchial e, the pancreas, salivary glands and the gastroestinal mucosa, do not function normally beuse of the thick, abnormal physiochemical propies of the mucus. The pancreatic ducts become structed by this abnormal mucus with atrophy d fibrosis of the alveoli leading to pancreatic ildigestion and, eventually, to fibrotic replacent of the islets of Langerhans with abnormal icose tolerance and even diabetes. In the lungs, deranged mucous secretion produces bronchiolar obstruction with bacterial proliferation and decreased respiratory capacity. The respiratory symptoms and signs range widely from occasional cough and recurrent respiratory illness to frequent paroxysms of severe cough, wheezing, dyspnea, diffuse coarse rales throughout the lung fields, anteriorposterior thoracic widening and clubbing of the fingers and toes. Nasal polyps develop for unknown reasons with some frequency in this disease. In the intestinal tract changes not wholly understood interfere with the absorption of fat, fat soluble substances and protein even when the absent pancreatic enzymes are replaced by pancreatic extracts. Prolapse of the rectum occurs in about 20% of the patients. Liver involvement may slowly evolve from biliary obstruction culminating in biliary cirrhosis in 5% of the patients. In the newborn infant, the abnormal mucus and lack of pan-

Cystic fibrosis is an autosomal recessive genetic disorder of the exocrine glands which has a frequency of 1:2,000 live births. This disease presents four challenges to the physician and his health care team. Through the Cystic Fibrosis Centers sponsored by the Cystic Fibrosis Foundation, the Missouri State Health Department is helping physicians and their patients to recognize and manage this chronic disease. The authors are from the Department of Child Health, University of Missouri School of Medicine. This work was supported in part by funds for a Center Grant from the Cystic Fibrosis Foundation.

creatic proteolytic enzymes may result in a form of intestinal obstruction called meconium ileus.

This disease presents four challenges to professionals in health care: (1) diagnosis may be difficult if the wide spectrum of clinical manifestation is not appreciated; (2) treatment is complicated and frequently uncertain because the variability in disease expression makes controlled studies difficult; (3) research progress has been arduous because fundamental understanding of cell chemistry and physiology have required development and exploration; and (4) helping patients and their families to live with this chronic disease requires considerable attention and is the objective of a growing private foundation (the Cystic Fibrosis Foundation) and state health departments such as the Missouri State Division of Health.

1. *The Challenge of Diagnosis*

Few diseases present in so many different forms, degrees of severity and at different ages as does CF. Fig. 1 gives a panoramic view of the common manifestations and the ages when they most frequently arise. Disturbances at later ages result from the primary system involvements.

These manifestations and their combinations can only suggest the diagnosis which must then be confirmed by specific tests. Measuring the amount of sodium or chloride or both in sweat is the basic diagnostic approach. The method used is important for obtaining reliable results. The most widely utilized technique is pilocarpine iontophoresis using a freshly prepared solution of pilocarpine an the electrode described by Gibson and Cooke It is crucial to know that at least 50 mg of swea must be collected for reliable results and the sod um or chloride concentration titrated. Flame pho tometry for sodium and the chloride method c Schales and Schales are well suited to these sma volumes. Recent experience with direct readin chloride electrodes and other automated ap proaches have proven much less reliable and sul ject to considerable distortion. A single determina tion is never adequate to support a diagnosis c such grave import. Values consistently above 6 mEq/liter for each ion are critical for the con firmation of this diagnosis. Occasionally, borde line values need to be repeated over a period c many months prior to diagnosis of the disease i such a patient. There is no relationship betwee the sweat chloride concentration and the severit of the disease. The sweat glands in newborn in fants are immature and testing before the age c three to six weeks requires careful technique an repetition. The sweat salt concentration graduall increases with age but values above 70 mEq/lite or 80 mEq/liter in adults are abnormal.[5]

More than four-fifths of the patients have enoug pancreatic destruction to have greatly reduce trypsin and chymotrypsin in the stools. The latt enzyme persists in the stools past infancy since it not destroyed by other proteolytic enzymes in th intestine. Measurement of stool trypsin and chym

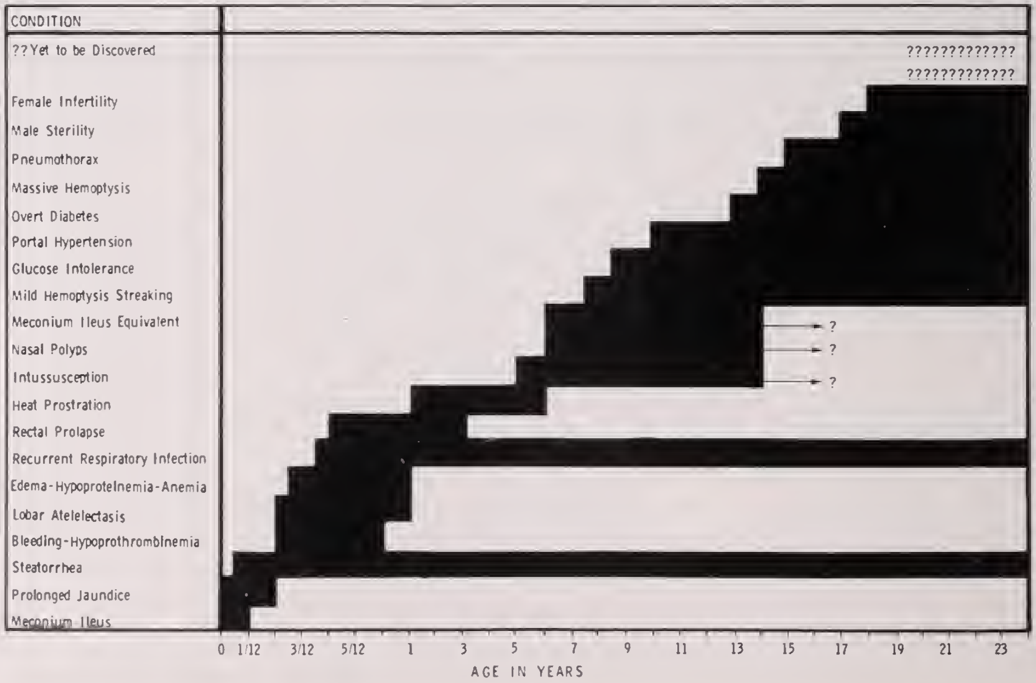

Fig. 1

rypsin is very useful as an additional diagnostic ool.[6] CF is the most common cause of pancreatic nsufficiency in childhood. Malabsorption or ste-torrhea can be quantitated only by a three-day at balance. A number of screening tests in current se can indicate qualitative defects in fat absorp-ion. These tests are not critical for the diagnosis of F, however.

In the presence of pulmonary involvement, putum or throat cultures frequently will show the resence of certain common bacterial organisms, articularly Pseudomonas species and Staphylococ-us aureus. The presence of such bacteria in the ulture from a patient with respiratory illness war-ants the performance of a sweat test. In some hildren or young adults with minimal clinical anifestations, observations over a period of time ill be necessary to detect evidence of clinical isease even in the presence of an elevated sweat hloride. Hypoadrenocorticism, severe growth fail-re and ectodermal dysplasia are some conditions ther than cystic fibrosis in which elevated sweat hlorides may be found. Diagnosis is probably most ffectively confirmed in centers with considerable amiliarity with all the clinical variability of the isease. The sweat test also requires continuous onitoring by individuals with a high degree of amiliarity and involved in its frequent perform-nce since it is readily subject to many errors and istortions.

The Challenge of Treatment

All present treatments for cystic fibrosis are es-ntially symptomatic. This discussion will be di-ided into gastrointestinal, pulmonary and general herapeutic approaches.

Malabsorption in cystic fibrosis is due in part to he absence of pancreatic enzymes. Commercial ancreatic enzymes from animal sources are uti-zed as substitution therapy (Viokase® and Cota-me® are examples). There is minimal difference etween the preparations available. In infants, the owder is most appropriate while capsules and com-ressed tablets are preferred by older children. The ose is determined by titration in the individual atient up to about ten tablets or capsules per meal. n many patients, the large foul stools improve with ancreatic supplementation and the compensatory oracious appetite decreases. Dietary management cystic fibrosis requires primarily a calorie intake dequate to meet the needs of the patient which ay be increased by stool losses and increased ertion from coughing. Normal fat intakes are ell tolerated by most patients while some find hat avoidance of fatty foods will reduce the volume of the stools. As in all patients with steatorrhea, a supplement of vitamins A, D, E and K is recommended in a water dispersible form. Preparations containing 5,000 units of Vitamin A, 400 units of Vitamin D and 25 mg of Vitamin E in 0.6 cc are available for infants and similar amounts in tablets for older children and adults. Five milligrams of Vitamin K_1 can be given weekly.

Management of the pulmonary involvement consists of the treatment of pulmonary infections, pulmonary physical therapy and inhalation of mists or bronchodilators or both. Emphasis is primarily upon the bronchial toilet. Because the normal mechanisms for clearing the tracheo-bronchial tree of secretions, inhaled particles and bacteria do not function normally, physical therapy using multiple positions is performed twice or more daily to promote drainage of pulmonary secretion. In selected patients, inhalations of mucolytic agents or bronchodilators have been utilized to liquify the secretion and to assist in its removal from the lungs. Small infants and children who have not learned to expectorate swallow their sputum and its presence may not be appreciated unless large quantities are swallowed and produce vomiting.

Sleeping in mist tents with the mist generated by ultrasonic nebulizers with 10% propylene glycol or half normal saline solutions has been a traditional regime. Recent investigations have shown that the amount of water actually reaching the smaller bronchioles is a very small percentage of that nebulized and that improvement in pulmonary function is controversial. Nevertheless, some patients appear to benefit from mist tent therapy. In fact, some of the above-described pulmonary therapy is still not scientifically evaluated since the variability of the natural course of the disease presents formidable problems for precise quantitative evaluation.

The copious pulmonary secretion provides an environment conducive to bacterial colonization. As earlier mentioned, coagulase positive staphylococci and pseudomonas aeroginosa are the most frequent organisms. It would certainly appear justified to presume that such intensive bacterial proliferation and metabolism in the pulmonary tree plays an active role in the pathogenesis of progressive lung damage. However, the specific long-term influence on the obstructive lung disease has been difficult to appraise. There is general agreement that appropriate and intensive antibiotic therapy is the cornerstone of the pulmonary therapeutic program. The staphylococcus must be considered a pathogen and treated energetically with an antibiotic to which it is sensitive. Some patients have minimal pulmonary involvement and receive antibiotic therapy during episodes of acute respiratory illness while others benefit from continuous antibiotic treatment with cultures at regular intervals to watch for changes in organisms and their antibiotic sensitivity. Since few diseases have such poor correlation between physical and roentgen findings in the lungs and since it is difficult to distinguish infection from the elaboration of copious pulmonary secretions at the clinical or laboratory level, the physician finds evaluation of antibiotic management difficult. The usual principles are to treat respiratory exacerbations or chronic involvement in a very intensive fashion with even multiple antibiotics and as large doses as possible for protracted intervals or continuously depending on the severity of the underlying state of pulmonary disease.

3. *Challenges in Understanding Cystic Fibrosis*

Since the study of families having a child with cystic fibrosis has shown an incidence of the disease in one fourth of their siblings, classification of the disease as an autosomal recessive genetic disorder suggests that the concept of an abnormal gene related to alteration in a single enzyme should apply. During the past few years, a large number of research observations have indicated the complexities which must be understood before any such relationship between genetic abnormality and mechanism of disease can be defined. Starting with the hypothesis that the elevated sweat salt concentration is close to the genetic defect, studies on the sweat secretory process have shown that there is a defect in reabsorption of sodium and chloride in the tubule of the sweat gland.[7] Sweat from a patient with CF will produce a similar defect in the reabsorption of sodium when injected into the parotid gland duct of the rat or profused into the isolated sweat gland of normal man. These observations indicate that there is a substance in the sweat which interferes with electrolyte reabsorption in an otherwise normal sweat gland. Spock using rabbit tracheal ciliated epithelium,[8] Bowman using oyster gills[9] and, more recently, others using ciliated cells from various sources[10] have found that serum from patients with CF will inhibit or disorganize the ciliary beat. Serum from obligatory heterozygotes, the parents of patients, has the same effect with a high degree of frequency. These biological assays have not yet proven to have the reliability necessary for clinical use in identifying the heterozygote or carrier state. The ciliary inhibiting cystic fibrosis factor appears to be a relatively small molecule of less than 10,000 molecular weight which is bound to gamma globulin in the serum At present, attempts to isolate and characteriz this factor are underway in a number of laboratories. Its presence in the heterozygote supports it importance and potential proximity to the gen defect.

Cell cultures of skin fibroblasts, lymphocytes an other cells from patients with cystic fibrosis an heterozygotes are being studied in the hope tha such *in vitro* systems will shed light on certai membrane and metabolic processes.[11]

Another research approach involves the contr of exocrine gland excretion by the sympatheti nervous system. The catecholamines, epinephrin and nor-epinephrine, for example, act upon th β-adrenergic receptors in the secretory cells t release macromolecules such as amylase from th pancreas. Stimulation of the α-adrenergic receptor stimulate the secretion of ions, such as bicarbonat and water from the pancreas. It has been suggeste that a further understanding of these control mechanisms in CF might help to clarify the pathophysiology of the disease. Recently, a potential anima model based on such control mechanisms has bee produced in our laboratories.[12]

4. *The Challenge of Helping Patients and Thei Families*

The diagnosis of cystic fibrosis in childhood is a overwhelming event to the patient and his famil The amount of support and education of a seemingly myriad of details concerning his managemen the commitment of time and money and the nee for expertise from disciplines such as physical the apy, respiratory therapy, microbiology, nutritio and social service, in addition to experienced med cal care, seem to fall beyond the immediate capacity of most family physicians or pediatrician In 1957, the National Cystic Fibrosis Researc Foundation (NCFRF), a private foundation cu rently named Cystic Fibrosis Foundation, was o ganized by parents of CF patients and other inte ested medical and lay volunteers. This foundatio has as its primary purpose the promotion of car education and research in this disease. One of th Foundation's activities is to promote better patie care by supporting Cystic Fibrosis Centers in med cal centers throughout the country where a nucle of professionals could make their experience wit CF available to all members of the medical pr fession as well as provide the team function various disciplines necessary for the care of th CF patient and his family.

A group of recognized authorities in this diseas

CYSTIC FIBROSIS CENTERS IN MISSOURI

Location	*Director*
St. Louis Children's Hospital 500 South Kingshighway St. Louis, Mo. 63110 314/367-4447 314/454-3080	**Dr. Donald Strominger**
Children's Mercy Hospital 24th at Gillham Kansas City, Mo. 64108 816/471-0626, Ext. 463 or 464	**Dr. V. F. Burry**
Cardinal Glennon Memorial Hospital for Children 1465 South Grand Blvd. St. Louis, Mo. 63104 Hospital—314/865-4000 Office—314/638-4010	**Dr. Anthony Regent**
University of Missouri Medical Center 807 Stadium Rd. Columbia, Mo. 65201 314/882-4932	**Dr. Calvin Woodruff Dr. Giulio Barbero**
University of Kansas Medical Center 39th and Rainbow Kansas City, Kan. 66103 913/831-6300	**Dr. Joseph Kanareck (accepts patients from Missouri)**

Fig. 2

visit the centers periodically to maintain standards of information, and their directors attend annual meetings at which advances in research and treatment are discussed. Support for the NCFRF comes from lay chapters throughout the country. The membership consists of parents, patients and other interested individuals who not only raise funds through various activities, but help each other with meetings, newsletters and campaigns for public education. Fig. 2 lists NCFRF supported centers in Missouri.

In Missouri, financial help has been appropriated by the state legislature and is available to all patients with CF through the Centers recognized by the Cystic Fibrosis Foundation. The long term costs of antibiotics and pancreatic enzymes alone can be a burden to people of moderate means as well as to those of more limited income, and there is no means test for these services. A major facet of the care is help and counseling around the adaptation to a chronic disease needing such intensive therapy and having unpredictable variability in its course. The physician and all other staff provide information and a variety of supportive and constructive responses to the needs of the child and the family.

The continued vigilance, time demands for therapy, constraints resulting from episodes of illness and uncertainty in the ultimate outlook are a sustained burden borne by the parents. The prognosis has strikingly changed in the past few decades so that more than 50% of the patients live well into the second decade with an increasing number of CF patients moving into adulthood throughout the country. This shift in the outlook has proferred hope, particularly in light of the extensive research effort which may result in more specific therapy in the next decade. It is, thus, justifiable and realistic that all professionals have a hopeful and positive outlook toward this disease—an attitude of key importance in helping the CF patient and his family.

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Scientific Sessions Important to Every Physician!

117th MSMA ANNUAL SESSION

April 17-20, 1975 St. Louis Chase-Park Plaza Hotel

ROBERT J. STANLEY, M.D. *and*
STEVEN LEICHTER, M.D., *St. Louis*

Pancreatic Glucagonoma: A Clinical-Angiographic Correlation

Case Report

In 1966, the first glucagon secreting alpha cell carcinoma of the pancreas was reported from this medical center.[1] Since that time, a few other isolated cases have appeared in the literature. A benign, non-functioning alpha islet cell tumor weighing 2.5 kg was reported recently.[2] This tumor was hypervascular and had areas of dense tumor stain on arteriography. A smaller, densely staining, malignant alpha islet cell tumor with vascular hepatic metastases also was described recently.[3] This patient manifested clinical evidence of increased glucagon production.

The second patient to be seen at this medical center with a well documented glucagon secreting islet cell carcinoma of the pancreas was recently evaluated with angiography as well as extensive metabolic and electron microscopy studies. In view of the rarity of this tumor as well as the striking angiographic findings, a single case report seemed appropriate.

A 53-year-old woman requiring more than 300 units of NPH insulin per day to control persistent hyperglycemia was found to have a large glucagon-secreting islet cell carcinoma of the pancreas. The angiographic findings were more consistent with those seen in a cystadenoma or cystadenocarcinoma of the pancreas. The striking clinical history and radioimmunoassay studies limited the diagnosis to a functioning islet cell tumor, presumably a glucagonoma. Dr. Stanley is from the Mallinckrodt Institute of Radiology, Washington University School of Medicine. Dr. Leichter is from the Department of Medicine at Washington University and a Trainee in Metabolism supported by Training Grant #AMO5027, National Institutes of Arthritis, Metabolism and Digestive Diseases.

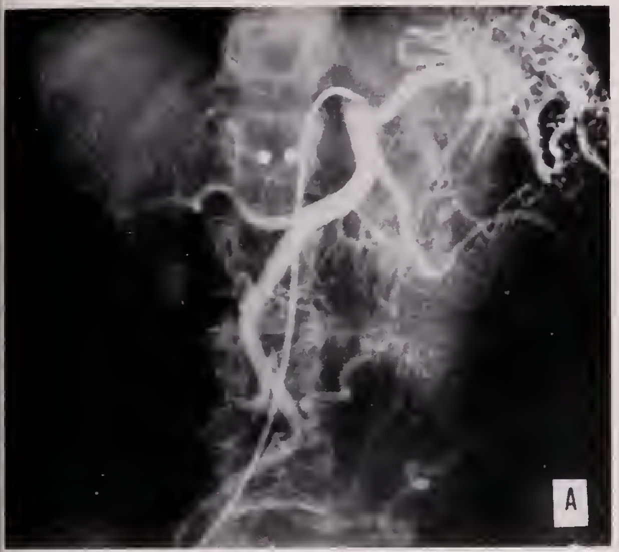
Case Report

A 53-year-old woman was admitted to Barnes Hospital in February of 1973 for regulation of diabetes mellitus. She had been well controlled with 500 mg of tolbutamide per day for nine years. During the year prior to admission, however, she had required increasing doses of tolbutamide and, later, insulin to treat her diabetes. On admission, she was taking more than 300 units of NPH insulin/day to control her persistent hyperglycemia.

Initial physical examination disclosed the presence of a hard, non pulsatile, fixed 5 cm x 6 cm left upper quadrant mass, severe cachexia and a persistent, resting tachycardia. Laboratory studies showed a serum calcium of 13.0 mg/dl; phosphorus, 1.9 mg/dl; and ionized free calcium, 8.0 mg/dl. Radioimmunoassay of serum parathormone concentration with an antibody specific for native parathormone measured no detectable immuno-activity. Radioimmunoassay for morning, fasting, serum glucagon with two different antibodies specific for pancreatic glucagon revealed a concentration of 1,400 pgm/ml (normal = 50-250 pgm/ml).

Selective arteriography of the celiac axis demonstrated multiple tumor vessels in the region of the tail and body of the pancreas (Fig. 1A). The splenic artery appeared encased and distorted. Enlargement of the left gastric and right gastroepiploic arteries provided a collateral blood supply to the spleen. In the capillary phase, an extensive irregular tumor blush was evident (Fig. 1B). Numerous enlarged veins coursed over the tumor. The increased number was partly related to the occlusion of the splenic vein (Fig. 1C). Using magnification technique, selective injection into the dorsal pancreatic artery revealed this vessel to be one of the major vessels feeding the tumor, confirming its pancreatic origin (Fig. 2). In view of the striking clinical history, the arteriographic diagnosis was limited to a functioning islet cell tumor, presumably a "glucagonoma."

At laparotomy, a large, highly vascular multicystic tumor was noted in the region of the pancreas. No normal pancreatic tissue was seen. Light and electronmicroscopy revealed a poorly differentiated islet cell carcinoma containing some cells similar to alpha cells and others not characteristic for any specific type of pancreatic cell. The patient was treated with intravenous 5-fluorouracil, 750 to 1,000 mg per week and oral phenoxybenzamine, 40 mg/day. Phenoxybenzamine



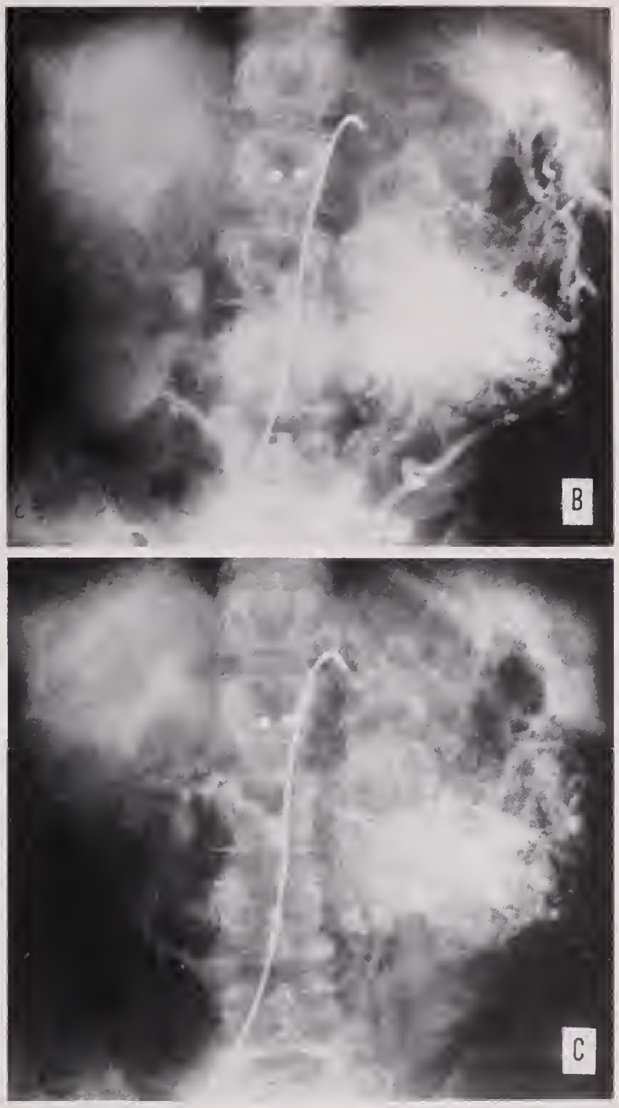


Fig. 1A (A) Selective celiac arteriogram demonstrates encasement and distortion of the splenic artery. The left gastric and right gastroepiploic are enlarged, providing collateral blood supply to the spleen. Early filling of numerous tumor vessels is evident in the general area of the body and tail of the pancreas. (B) Capillary phase reveals extensive tumor stain throughout the entire pancreatic bed, defining a tumor mass approximately 7 cm x 11 cm. (C) Venous phase demonstrates persistent stain of the tumor. Numerous tortuous veins course above, over and under the tumor, both draining the tumor and providing collateral flow due to splenic vein occlusion.

was used to reduce the hyperglycemia associated with her hyperglucagonemia.[4] Three months after diagnosis, the patient developed steatorrhea which was relieved by exogenous pancreatic extract. At a six-month follow up, she had gained 27 pounds, required 210 units of insulin per day and was relatively active. A serum gastrin level at that time was within normal limits.

Two months later, she suddenly developed melena and watery diarrhea without hypokalemia or alkalosis. On gastroscopy, a few superficial gastric and upper duodenal ulcerations were seen. On the evening following gastroscopy after all bleeding had ceased, the patient vomited, aspirated and suffered an irreversible respiratory arrest.

DISCUSSION

Islet cell neoplasms have been shown to secrete insulin, gastrin, glucagon and possibly secretin.[1, 5, 6] In the past two decades, several distinct clinical syndromes have been associated with the hypersecretion of these hormones including the hypoglycemia of insulinoma, the Zollinger-Ellison Syndrome and the syndrome of pancreatic cholera.[7] Ectopic production of other hormones not normally elaborated by the pancreas also has been described.[5, 8]

Glucagon secreting tumors have not been associated with a clearly defined syndrome. The patient seen in 1966 at this center was noted to have mild diabetes mellitus and an eczematoid dermatitis.[1] One other patient with an alpha cell tumor had severe diabetes mellitus and hyperglucagonemia. However, the glucagon was measured by a relatively nonspecific assay and the high glucagon levels reported may have represented nonpancreatic glucagon.[9] In the present case, diabetes mellitus, severe cachexia and a persistent tachycardia without other evidence of heart failure were found. No patient, including this one, has been shown to be a ketosis-prone diabetic. Further evaluation of the clinical characteristics of the hyperglucagonemic state is now possible due to recent advances in radioimmunoassays for glucagon.[10]

The present case represents the largest reported glucagon-producing islet cell tumor studied angiographically. Without a knowledge of the clinical picture, the primary angiographic diagnosis would

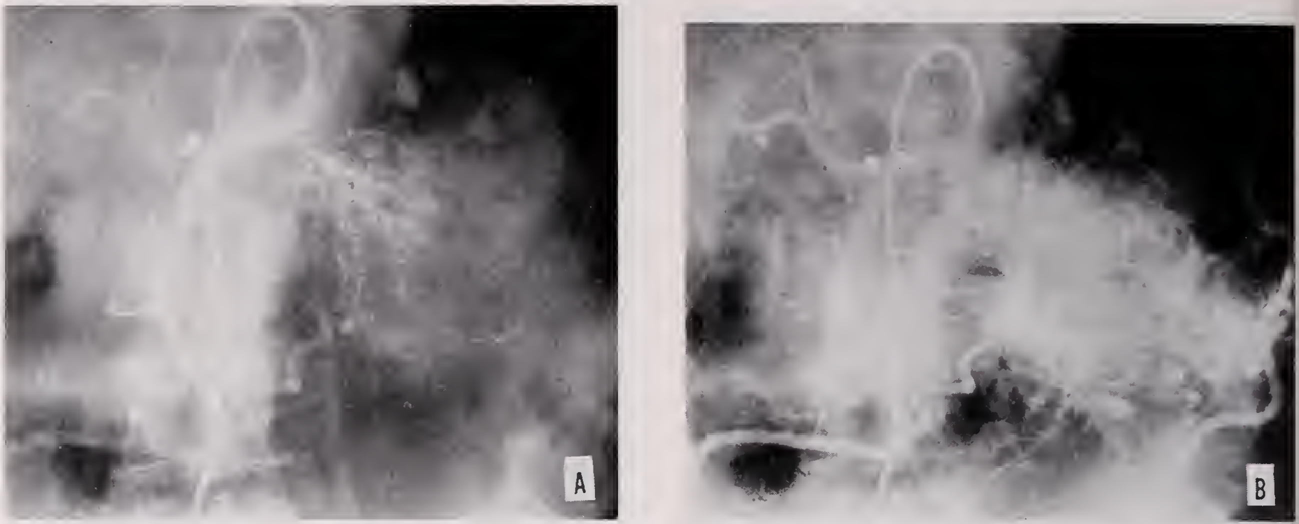


Fig. 2 (A) Injection of dorsal pancreatic artery, magnification technique defines early filling of extensive tumor vessels, indicating pancreatic origin of tumor. (B) Late arterial phase reveals extensive network of tumor vessels fed primarily by dorsal pancreatic artery, resulting in intense tumor stain.

have been cystadenoma or cystadenocarcinoma based on its size and vascularity. Most pancreatic cystadenomas have been found to be angiographically hypervascular and capable of attaining great size. Recently, however, several distinctly hypovascular cystadenomas have been reported.[11] While islet cell tumors are characteristically vascular with a prominent tumor blush, the size of this lesion is distinctly out of the ordinary. The vast majority of functioning islet cell tumors are in the 1 cm to 2 cm diameter range; they have relatively few obvious tumor vessels and are recognized primarily by their tumor blush, which produces an area of increased contrast density compared to the surrounding normal parenchyma.[12-15] The combination of nonketotic diabetes mellitus and angiographic finding similar to those described here should raise the suspicion that a "glucagonoma" is present.

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The American Board of Family Practice announces that it will give its next two-day written certification examination on Nov. 1-2, 1975. It will be held at five centers geographically distributed throughout the United States. Information regarding the examination may be obtained by writing to Nicholas J. Pisacano, M.D., Secretary, American Board of Family Practice, Inc., University of Kentucky Medical Center, Annex #2, Room 229, Lexington, Ky. 40506.

Please Note: It is necessary for each physician desiring to take the examination to file a completed application with the Board office. Deadline for receipt of applications in this office is June 15, 1975.

MAURICE B. ROCHE, M.D., ***St. Louis***

Cervical Spinal Cord Trauma

Case Reports

The purpose of this study of 41 cases of traumatic quadriplegia was to ascertain how successfully the patient's goal of independent living was realized when he reached the plateau of maximum benefit from hospitalization and was discharged. Those patients with complete cord lesions (14 cases) had no prospect of neurological recovery. Nevertheless, they were trained in developing whatever functional potential had been spared. This was not sufficient, however, to alter their status of dependency. Those with incomplete cord lesions (27 cases) had a greater range of recovery possibilities, including return to a minimal neurological deficit or none at all.

Tables are presented which offer one-line capsule histories of the 41 quadriplegics. The condition of their hand function, ambulation, bladder and bowel was recorded at the time of admission and upon discharge from the hospital. Comparison of these values served as an objective measurement of each patient's accomplishment. When so assessed at the time of discharge, 67% of incomplete quadriplegics had realized their goal of independent living.

Material and Methods

The Locale

The locale of this study is a Rehabilitation Center within an acute-care, 675-bed teaching and research hospital. It is provided with a ward of 44 beds accommodating patients from neurosurgical, orthopaedic, urological, medical and surgical referral sources. This ward is staffed with well-trained nurses in sufficient numbers to provide good care for persons with spinal cord injuries. An emergency room with well-trained personnel, both medical and surgical intensive care units and operating room suites provide standby availability. The hospital has had a heliport in service since 1964.

The Material

The material comprises a series of unselected and consecutive cases of spinal cord injuries. The first patient was admitted in 1966. Information was gathered on 106 cases up to and including admissions during 1972. Eighty-six cases (81%) were caused by trauma. The remaining 20 cases (19%) were caused by disease. These latter were excluded from further study.

Of the 86 trauma cases, 45 (52%) had cervical vertebral involvement (quadriplegia) and 41 (48%) had dorsal or lumbar vertebral involvement (paraplegia) or both. Following a generalized scanning of this material, attention was restricted thereafter to the patients with traumatic cervical spinal cord injury (quadriplegics) for the purpose of determining the recovery benefits from their hospitalizations.

A study was made to ascertain how successfully quadriplegic patients reached their goals of independent living in response to their hospital programs of intensive recovery therapy. This clinical critique includes tables which offer one-line capsule histories of the 41 quadriplegics who were treated. Dr. Roche is Medical Director Emeritus of the Rehabilitation Center and Consultant in Orthopedic Surgery at St. John's Mercy Medical Center and Associate Clinical Professor Emeritus of Orthopedic Surgery at the St. Louis University School of Medicine.

It was recognized that the extent of the patient's recovery was predetermined by whether the initial injury had produced a complete or an incomplete spinal cord lesion. The 45 quadriplegic cases, therefore, were differentiated as to being complete (17 cases) and incomplete (28 cases). During hospitalization, three deaths occurred in the complete group and one in the incomplete group. Exclusion of these yielded these corrected figures: total quadriplegics, 41 cases; complete quadriplegics, 14 cases (34%); and incomplete quadriplegics, 27 cases (66%).

Norms for Evaluation

Norms for evaluating the functional status of the patient's recovery at the time of hospital discharge were difficult to establish and, at best, imprecise. Criteria similar to those employed by Bosch, Stauffer and Nickel,[1] which are the return of function to the lower and upper extremities and to bladder and bowel control, were selected.

Ambulation was graded as follows:

0%—No ambulation possible.

25%—Nonfunctional in spite of bracing, equipment, maximum assistance.

50%—Functional with aid of bracing, equipment and assistance.

75%—Independent ambulation plus bracing or equipment or both but no assistance.

100%—Independent ambulation.

Hand function was graded as follows:

0%—Upper extremity (UE) muscles zero-trace (O-TR). Mouth stick activities only.

25%—Proximal UE muscles poor-fair (P-F). No wrist-hand function. Limited (nonfunctional) hand-wrist motion possible with overhead slings, ball-bearing feeders and quad-quip splints.

50%—Proximal UE muscles fair-good (F-G). Wrist extensors, P-F; hand muscles—O. Hands functional only with overhead slings and quad-quip splints.

75%—Proximal UE muscles, F-G; wrist-extensors, F-G; hand muscles—O. Hands functional only with wrist-driven flexor hinge splints.

100%—Hands functionally independent of adaptive equipment.

Bladder—Not graded. Status at time of hospital discharge was identified as follows: FR—Functional recovery, CF—Catheter free, IC—Indwelling catheter.

Bowel—Assessment at time of discharge limited to following conditions: FR—Functional recovery, BR—Bowels regulated.

The ratings of (1) functional recovery, (2) independence and (3) dependence are used to indicate the patient's status at the time of discharge from the hospital.

Functional recovery is intended to imply complete independence afforded by the return of motor and sensory functions to normal patterns.

Independence implies independent ambulation and hand function (with or without adaptive equipment) sufficient for the performance of all activities of daily living, residual neurological deficits notwithstanding.

Dependence status includes the so-called "quad-independence" category which comprises approximately half an hour of assistance morning and evening with skin, bowel, bladder routines and dressing. For that reason, no functional ratings of complete quadriplegics were made.

Results and Discussion

A. Complete Quadriplegia

When quadriplegia is complete, damage to the cervical cord is beyond any physiological return *below* the level of the lesion. However, *above* the functional level of the cervical cord lesion, the existing innervation of uninvolved muscles, however little, allows training in some aspects of self-help. Advantage is taken of these residual uninvolved motors to salvage whatever acts of independence may be recoverable. Inadequate function is supplemented by functional bracing.[2]

In this series, there were 17 patients classified as complete quadriplegia. Of these, three died during the course of hospitalization. (Two of these had lesions at the C5/C6 level and one at the C6/C7 level.) Of the remaining 14 patients, three were involved at the C4/C5 level, six at the C5/C6 level and five at the C6/C7 level.

Various tables presented hereafter, which have to do first with the complete and, subsequently, with the incomplete quadriplegic groups, summarize information garnered from their records. Included are such facts as the patient's age; the condition of his ambulation, hand function and bowel and bladder on admission and at time of discharge; the duration of hospitalization; the incidence of surgery; and the disposition of the patient at the time of his discharge from the hospital. These tables indicate the benefit each patient obtained during the course of his hospitalization (Tables 1-8).

Case Reports

Case #89. A 50-year-old construction foreman was admitted on the day of his accident. He was able to move his head and facial muscles and to slightly move both shoulders. During the course of his hospital stay, no muscle recovery occurred. As a substitute for the functional loss of his upper extremities, a mouthpiece was fabricated by the consulting dentist. With training in its use, the patient accomplished writing, typing, painting, page turning and other things. He operated an electric wheelchair by means of his chin. At the time of his discharge (to another rehabilitation facility), he had mastered hygienic activities and feeding and communication skills. He also showed promise of becoming a satisfactory (though unofficial) counselor for teenage

TABLE 1

COMPLETE QUADRIPLEGIA FX-DISL C4/C5 LEVEL

Case #	*Age*	*Admission* AMB %	HF %	BL	BOWL	*Discharge* AMB %	HF %	BL	BOWL	*Hospital Days*	*Surg.*	*Disposition*
21[*]	52	0	0	0	0	0	25	CF	BR	49	—	H
70[†]	20	0	0	IC	BR	0	25	CF	BR	150	ANT.	H
89[*]	50	0	0	0	0	0	25	CF	BR	317	—	T

[*] Admitted on date of accident (D/A).
[†] Admitted as transfer 72 days from D/A.
AMB—Ambulation; HF—hand function; BL—bladder; BOWL—bowel; CF—catheter free; IC—indwelling catheter; BR—Bowels regulated; SURG—surgery (ANT.—cerv. interbody spinal fusion or POST—laminectomy); H—home; T—transfer to another facility.

fellow quadriplegics. Outpatient follow-up programs and appointments from the urologist for interval urological follow-up examinations are important aspects of discharge preparations except, of course, for those patients being transferred to another rehabilitation facility.

TABLE 2

COMPLETE QUADRIPLEGIA FX-DISL C5/C6 LEVEL

Case #	*Age*	*Admission* AMB %	HF %	BL	BOWL	*Discharge* AMB %	HF %	BL	BOWL	*Hospital Days*	*Surg.*	*Disposition*
5[*]	20	0	0	0	0	0	25	CF	BR	107	—	T
10[†]	45	0	25	IC	0	0	50	IC	BR	186	POST	H
36[*]	25	0	0	0	0	0	0	IC	BR	115	ANT.	T
69[*]	15	0	0	0	0	0	50	CF	BR	77	—	T
81[*]	20	0	0	0	0	0	25	CF	BR	202	—	H
87[*]	26	0	0	0	0	0	75	CF	BR	179	—	T

[*] Admitted on D/A.
[†] Admitted as transfer 70 days from D/A.

Case # 87. This 26-year-old patient was admitted on the day of his accident. There was a C6 functional level. His diaphragms moved well. His intercostal muscles were paralyzed. Mass reflex spasm was present and involved his lower extermities, often carrying over into his upper extremities and being stimulated by any input below the level of the lesion. These episodes of autonomic hyperreflexia occur with lesions above the outflow of the splanchnic nerves or above T6. Pathologic autonomic reflexes are manifested by constriction of vessels, hypertension, bradycardia, sweating, severe headache and "goose flesh." Perhaps the most common causes of hyperreflexia are distention of the bladder or the rectum. Subsequent complications such as cerebrovascular accidents (stroke) and renal failure, have been noted. Therapy includes drug administration in the early phase. If there is no subsidence, there may be a need to consider surgical procedures later.[3]

TABLE 3

COMPLETE QUADRIPLEGIA FX-DISL C6/C7 LEVEL

Case #	*Age*	*Admission* AMB %	HF %	BL	BOWL	*Discharge* AMB %	HF %	BL	BOWL	*Hospital Days*	*Surg.*	*Disposition*
22[†]	27	0	0	IC	0	0	50	CF	BR	141	POST	H
40[†]	31	0	0	IC	BR	0	75	CF	BR	106	—	H
58[†]	19	0	0	IC	BR	0	75	IC	BR	97	—	T
59[*]	58	0	0	0	0	0	50	IC	BR	43	—	T
86[†]	23	0	25	IC	BR	0	50	CF	BR	210	POST	H

[*] Admitted on D/A.
[†] Admitted as transfers: Case #22—25 days from D/A; Case #40—88 days from D/A; Case #58—89 days from D/A; Case #86—65 days from D/A.

B. Incomplete Quadriplegia

Specific clinical syndromes have been described with reference to different manifestations of incomplete traumatic cervical cord injuries. The following are included:

1. *The syndrome of acute central cervical spinal cord injury.* This situation results from hematomyelia or edema of the cord. There is usually more motor impairment of the upper than the lower extremities, as well as bladder dysfunction and varying degrees of sensory loss. There may be no roentgenographic evidence of fracture or dislocation of the cervical spine.[4]
2. *The syndrome of acute anterior spinal cord injury.* The cause is usually a forcible flexion of the cervical spine which produces a fracture-dislocation of the cervical vertebrae with accompanying anterior cord damage.[5]
3. *Hemisection lesions* fall into the category of the Brown-Séquard syndrome. Most often, these accompany open lesions such as those resulting from stab or gunshot wounds.

In the following series of cases, 28 were categorized as incomplete traumatic cervical cord lesions. No further diagnostic allocation to more specific syndromes is offered. In this group, there was one fatality (C6/C7 level) during the course of hospitalization. Of the remaining 27 patients, two were involved at the C1/C2 level, four at the C4/C5 level, 11 at the C5/C6 level, eight at the C6/C7 level and two at the C7/T1 level.

TABLE 4

INCOMPLETE QUADRIPLEGIA C1/C2 LEVEL

Case #	Age	Admission AMB %	HF %	BL	BOWL	Discharge AMB %	HF %	BL	BOWL	Hospital Days	Surg.	Disposition
67*	37	75	75	IC	BR	FR	FR	FR	FR	37	—	H
104†	39	0	0	IC	BR	25	25	CF	BR	90	—	T

* Admitted on D. A.
† Admitted as transfer 56 days from D. A.

Comment: Discharge ratings: Functional recovery (one case): #67; Dependence status (one case): #104.

TABLE 5

INCOMPLETE QUADRIPLEGIA C4/C5 LEVEL

Case #	Age	Admission AMB %	HF %	BL	BOWL	Discharge AMB %	HF %	BL	BOWL	Hospital Days	Surg.	Disposition
9*	19	75	0	IC	FR	FR	FR	FR	FR	61	—	H
49*	31	25	0	FR	FR	FR	75	FR	FR	29	ANT.	H
78†	59	0	0	IC	BR	25	50	CF	BR	219	POST	H
101*	17	85	75	FR	FR	FR	75	FR	FR	10	—	H

* Admitted on D. A.
† Admitted as transfer case 97 days from D. A.

Comment: Discharge ratings: Functional recovery (two cases): #9 and #49; Independence status (one case) #101; Dependence status (one case): #78. Three cases, #9, #49 and #78, were diagnosed as having acute central cervical spinal cord syndrome.

CASE REPORTS

Case #78. A 59-year-old man had fallen from a height with immediate onset of total quadriplegia. Roentgenograms of the cervical vertebrae had failed to disclose any evidence of fracture or dislocation although well-developed cervical spondylosis was described. A posterior decompression laminectomy had been done and was followed later by some increased function in the lower extremities, but less so in the upper extremities.

At the time of his transfer to this facility, he had been receiving blood transfusions for a stress ulcer.

Additional complications included a nearly complete pyloric obstruction which required a subtotal gastrectomy and gastrojejunostomy, thrombophlebitis of the right lower extremity and moderately severe degenerative arthritis which was most marked in the fingers of both hands. This patient acquired a limited ability for self-care. He was able to ambulate only with assistance.

TABLE 6

INCOMPLETE QUADRIPLEGIA C5/C6 LEVEL

Case #	Age	Admission AMB %	Admission HF %	Admission BL	Admission BOWL	Discharge AMB %	Discharge HF %	Discharge BL	Discharge BOWL	Hospital Days	Surg.	Disposition
3*	59	0	0	0	0	75	75	FR	FR	67	—	N.H.
15*	19	75	75	0	0	FR	75	FR	FR	16	—	H
16*	20	0	0	0	0	75	75	FR	FR	124	—	H
27*	19	25	25	FR	FR	75	75	FR	FR	33	ANT.	H
29*	24	0	0	0	0	50	50	CF	BR	255	—	H
31*	28	0	0	0	0	50	75	CF	BR	84	—	H
37†	19	0	25	CF	BR	50	75	CF	BR	246	—	H
44*	16	25	25	IC	0	75	75	FR	FR	40	—	H
64*	43	0	50	0	0	50	50	CF	BR	132	POST	H
91*	17	0	25	0	0	75	75	CF	BR	150	—	H
93*	45	0	0	0	0	75	75	FR	FR	60	—	H

* Admitted on D/A.
† Admitted as transfer case 75 days from D/A.

Comment: Discharge ratings: Functional recovery (no cases): Independence status (seven cases), #3, #15, #16, #27, #44, #91 and #93; Dependence status (four cases): #29, #31, #37 and #64.

Four cases, #3, #15, #44 and #93, were diagnosed as acute central cervical spinal cord syndromes. The roentgenograms of their cervical vertebrae were negative for fracture or dislocation or both. These patients manifested the neurological deficits common to this syndrome.

Crush fractures of the body of C5 and fracture dislocations of C4/C5 are reported to have the highest mortality of vertebral column injuries, a fact attributed to associated trauma of the respiratory centers.[6]

Case #27. A 19-year-old man underwent an anterior cervical interbody spinal fusion following reduction of his cervical spinal fracture-dislocation. At the time of his discharge, he had residual weakness of both hands, especially the left (left hand dominance) but not enough to prevent the normal performance of activities of daily living. While there persisted some weakness of the left lower extremity muscles, he developed an independent gait. He retained control of his bladder and bowel.

Comment: Discharge ratings: Functional recovery (three cases): #30, #90 and #105; Independence status (three cases): #8, #68 and #94;

TABLE 7

INCOMPLETE QUADRIPLEGIA C6/C7 LEVEL

Case #	Age	Admission AMB %	Admission HF %	Admission BL	Admission BOWL	Discharge AMB %	Discharge HF %	Discharge BL	Discharge BOWL	Hospital Days	Surg.	Disposition
8*	22	0	50	0	0	75	75	CF	BR	82	—	H
17*	23	0	0	0	0	50	75	CF	BR	105	ANT.	H
39*	35	75	75	FR	FR	FR	75	FR	FR	11	ANT.	H
68*	17	0	0	0	0	75	75	CF	BR	110	—	H
90†	29	75	75	CF	BR	FR	75	FR	FR	48	—	H
94†	66	25	50	IC	BR	75	75	CF	BR	132	ANT.	T
99*	18	0	75	0	0	25	FR	CF	BR	99	ANT.	H
105*	37	0	25	FR	FR	75	75	FR	FR	28	—	H

* Admitted on D/A.
† Admitted as transfers: Case #90—32 days from D/A; Case #94— 39 days from D/A.

Dependence status (two cases) #17 and #99. One case, #105, was diagnosed as an acute central cervical spinal cord syndrome.

Case #68. A 17-year-old boy was transferred from another facility within 24 hours after having sustained a fracture-dislocation of C6 on C7 plus immediate quadriplegia. Paralysis of the right lower extremity with less involvement of the left lower and both upper extremities were remarked during an admission examination. There also was paralysis of the bladder and bowel. His neck dislocation was reduced and stabilized by Crutchfield tong traction for six weeks. He was then fitted with a four-poster cervical brace and mobilized. He achieved independence in ambulation and hand function. At the time of his discharge he was catheter-free and his bowels were regulated.

TABLE 8

INCOMPLETE QUADRIPLEGIA C7/T1 LEVEL

Case #	*Age*	*Admission* AMB %	HF %	BL	BOWL	*Discharge* AMB %	HF %	BL	BOWL	*Hospital Days*	*Surg.*	*Disposition*
95*	24	25	75	CF	BR	25	75	CF	BR	25	ANT.	T
102†	23	50	50	N	N	FR	75	N	N	20	POST	H

* Admitted one year from D/A.
† Admitted 18 days from D/A.

Comment: Discharge ratings: Functional recovery (one case): #102 Brown-Séquard syndrome following open (gun-shot) wound. Dependent status (one case): #95 was admitted one year following D/A, for plastic surgical repair of decubiti. No alteration in quadriplegic status of "quad-independence" at time of hospital discharge.

C. Statistical Incidence

Causes of injuries included, first and foremost, the automobile which was responsible for 29 (64%), the largest group of casualties. Athletic injuries rated second in frequency. Nine in number (20%), they included swimming (four), wrestling (two), sledding (one), trampoline gymnastics (one) and pole vaulting (one). Falling from a height accounted for four. There was a blow on the head in one case; in another, there was a gunshot wound. Finally, one patient had a neck injury with partial strangulation when a neck scarf was caught in mobile machinery.

Of this quadriplegic population (45 cases including four deceased) 53% were within the 15- to 24-year age bracket. Eighty-four percent were males. The most frequently involved spinal level was C5/C6 with an incidence of 42%. C6/C7 level was next with a 33% frequency.

There was a postadmission mortality rate of four (9%). Three patients were complete quadriplegics, two were at the C5/C6 level and one was at the C6/C7 level. The fourth had an incomplete lesion at the C6/C7 level. (Since no postadmission deaths occurred among the 41 paraplegics, the mortality rate for the *total* group of spinal cord injuries [86 cases] was 5%.)

Bed Utilization

Over the six-year period, there were 41 quadriplegics who accounted for an average hospital stay of three and one-half months. Twenty-eight (68%) were admissions within 24 hours of the date of their injury. For them, hospital treatment included the acute as well as the rehabilitation phase of their disability needs.

Twelve patients were admitted at varied intervals (averaging 63 days) from the time of their injuries. This, the continuing rehabilitation phase of treatment, required intensive programs for achieving the maximum potential in the independent performance of hygiene activities, feeding, communication skills, upper extremity dressing, bladder training and emptying bag, skin inspection, transfer techniques, exercises (including wheelchair push-ups), maintenance of joint range of motion, homemaking activities and automobile driving. There also are the areas of vocation and psychological counseling, the continuation of educational pursuits and various social service attentions that need to be accomplished prior to discharge. The program is formidable and, indeed, is made doubly so should complications intervene.

(Continued on page 146)

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Education for the Leukemia Patient

Two years ago in this journal, members of the staff of the Cancer Research Center collaborated on an article describing the types of education necessary for all patients, particularly cancer patients, and the numerous benefits that accrue as a result. Reduced hospital stay, lowered readmission rates and increased patient cooperation with the treatment regimen are results cited in studies conducted with patients who received a systematic educational program.[1] Since that article was written, educational materials have been developed for the patients at the associated Ellis Fischel State Cancer Hospital.

A new development in patient education at the Cancer Research Center, which is the focal point of this article, is a program being designed for the patient with leukemia. These patients (average age is 50) are admitted to the nine-bed Clinical Research Unit (CRU) of the Cancer Research Center with a diagnosis of leukemia. The majority of these patients have acute myelocytic leukemia. However, there is a small population of adults with acute lymphocytic leukemia. Since 1971, 42 patients have been admitted to the unit for treatment with randomized chemotherapy administered until remission is achieved. The patient then returns to the unit monthly for week long observation and treatment.

We chose to explore the program being designed for this particular disease for two reasons: first, to illustrate the methods undertaken in the development of a patient education program and, second, to enlist the practitioner's aid in the continued education of the leukemic patient after the initial hospital stay.

At the outset of our research, a very interesting point became evident. Information concerning the child with leukemia abounds, but very little is written about the care and education of the adult leukemic. This is an unusual phenomenon since there are many more adults than children with leukemia.[2] Chemotherapy, the treatment choice for the majority of leukemics, is explored in existing literature but, unfortunately, not in terms a lay person would understand. While the side effects of the drugs are delineated, the compensation for the changes in bodily functions is left to the uncomprehending patient.

Several factors underscore the need for patient education both during hospitalization and following remission. Since the major portion of the management of the leukemic's illness rests in his and his family's hands, an educational program is mandatory.[3] Increased susceptibility to infection because of leukocyte immaturity or myelosuppression or both, and the danger of hemorrhage as a result of severe thrombocytopenia demand effective patient education. The program's emphasis must be on good hygiene, adequate rest and proper home care to allow the leukemic to lead a fairly normal life. In addition to the physiological ramifications of the disease, consideration of the psychological and emotional problems necessitates an educational program directed at the patient and his family.

Previously, education was undefined and fragmentary for the adult leukemic who was admitted to the nine-bed unit. A leukemic patient recounting his experiences at another hospital wrote, ". . . lacking clear guidelines, the doctor and staff follow an inconsistent pattern of disclosures which leaves the patient's desire for information or assurance unrequited and leaves him frustrated and depressed."[4]

Unfortunately, this statement was true for the staff and the patients on our unit. For example, a patient was diagnosed as having acute myelocytic leukemia. She achieved remission four months later while on a remission induction protocol utilizing 6-thioguanine and cytosine arabinoside. She remains in remission at the present time. During one of her admissions for chemotherapy, she stated that she had been trying to learn something about her disease from her encyclopedia. She did not understand why she became extremely exhausted while trying to maintain the same life pattern she had prior to the onset of leukemia. Most alarmingly, she indicated that her family expected her to die during each admission for chemotherapy. Because of this, the family lived in a constant state of tension. The patient had received verbal information

A new development in patient education at the Cancer Research Center is a program being designed for the patient with leukemia. The instruction, which begins in the hospital and is communicated to the health professional through a new discharge summary, will serve as a foundation for additional education and reinforcement by the family physician, dentist and public health nurse. Patricia Vannatta is Health Educator at the Cancer Research Center. Phyllis Harris is Director of Nurses and Adrena Mazzei is a Staff Nurse at the Center's Clinical Research Unit. This investigation was supported by Clinical Cancer Training Grant #CA-08018 from the National Cancer Institute.

about the disease during her previous admissions but, apparently, she and her family understood little of what had been taught and they were living with disturbing misconceptions.

Thus, the need for a program of education for the leukemic is plainly evident. As a result of the information gathered from patient interviews and a review of the literature, the staff determined the program should serve to (1) allay psychological apprehensions concerning the disease, (2) correct any misconceptions derived from ineffective teaching and (3) provide basic information necessary for the leukemic and his family to function as normally as possible.

Consequently, several objectives were concluded to be important in providing a foundation for the program. Clearly stated technical information must be provided to enable the patient and his family to understand and explain in their own words (1) what leukemia is; (2) how the disease affects normal body functions, including the effects of having lowered mature leukocyte, erythrocyte and platelet counts; (3) the meaning of remission; and (4) the role of chemotherapy in producing the drug-induced remission and possible resultant side effects.

The final set of objectives deals with the necessity for the patient's comprehension of directions given by health care professionals concerning his personal care. Infection is a major cause of death in the patient with acute leukemia, especially during periods of severe prolonged myelosuppression.[5] The program will teach the patient ways to avoid infection. One approach is to decrease reservoirs of pathogens and prevent autocontamination by establishing patterns of remarkably good personal hygiene. For example, on admission, the patient is evaluated by a dentist and dental hygienist, and a plan of preventive oral and dental hygiene is established. Included in this plan is specific instruction for the patient on the care of his teeth and gingiva during periods of myelosuppression and after remission. Even with the best of precautions, however, infections often occur at times of severe granulocytopenia. Thus, the patient and his family need to be able to identify symptoms of local and systemic infections and to know the course of action necessary upon detection of such symptoms.

Development of an educational program to meet these goals and objectives has been tedious and time consuming. The progress on the leukemia project has been dependent on the commitment of a number of staff members of the Cancer Research Center and the time generously donated by various consultants on the staff of the University of Missouri-Columbia.

Initially, a team composed of a health educator and three nurses from the staff of the CRU developed the goals and objectives of the educational program. As work progressed, it became apparent that the skills of other health team members were required if the myriad problems experienced by the leukemic were to be met. Additional health professionals—an artist, photographer and dental hygienist—joined the core team, who met weekly. Others who were consulted frequently about specific areas of program content were a hematologist/oncologist, dentist, psychiatrist, dietitian, professor of adult education and statistician.

Following the determination of the objectives for the program, the core team outlined the methods and procedures to be utilized for the successful completion of these objectives.

The prescription of an educational program is dependent on discovering how the patient views his problem. The initial evaluation will occur during the patient's admission interview with a member of the CRU nursing staff. The patient's understanding of leukemia and how it affects him will be accurately documented. This initial assessment will offer the nursing team the information necessary to form a teaching plan designed to meet the needs of a specific patient.

Each individual plan will consist of the following three components: (a) a series of slide/tape programs, (b) one-to-one instruction and (c) written reinforcement of instructions. This multimedia approach was selected in order to involve the patient in the program through as many of his senses as possible, to provide variety in the presentation of content and to utilize common educational styles that are familiar to our patient population. Each objective is developed in a visual segment of the program because it was felt that an audiovisual presentation would be understood most easily and accepted by the largest segment of the patient population regardless of education.[6]

The slide/tape series consists of four parts. A general introduction and a discussion of the normal anatomy and physiology of the hematopoetic system will initiate the program. An explanation of leukemia, remission, chemotherapy and randomization will follow in the second program. Several aspects of good hygienic practices including dental and oral hygiene, perineal care and proper diet will be delineated in the third program to aid the leukemic in preventing infection. The fourth section is designed to facilitate the patient's return to his community and to the routine of daily life. This program also will stress the signs and symptoms of infections, when to call the family physician, dentist or public health nurse and the importance of an adequate balance of rest and exercise. Each section of the program will assist the patient and his family in adjusting to physiologic limitations and in explaining these changes to friends and associates without embarrassment.

One-to-one instruction from the physician, the nurse and the hygienist will follow each audiovisual presentation. Questions will be answered and the patient will be given the opportunity to practice newly taught behaviors while he is in the hospital.

Written reinforcement of the slide program and individual instruction will be in the form of a pamphlet. It also will serve as a means of informing the patient's family physician and public health nurse what the patient has been taught so they may continue his health care without interruption. Each family physician will receive a copy of the pamphlet attached to the new multi-disciplinary summary (soon to be used at the Cancer Research Center). A copy of the patient-teaching plan written by the staff also will be included to enable the health professional to continue the educational plan while helping to evaluate its success.

Prior to its introduction to the patients on the unit, the program will be evaluated by a sample group of individuals without leukemia. Ease of understanding and the clarity of the material presented in the audiovisual programs as well as the readability of the pamphlet will be examined. The sample group will be similar to the patient population or approximately 50 years of age with at least an eighth grade education. This group will be given a test prior to and following exposure to the program to determine if an increase in the group's knowledge about leukemia has occurred.

Following the successful completion of pretesting, the program will be instituted on the unit. Evaluation will begin immediately and be continuous. Though the formal evaluation process is not yet final, the following procedures will be the primary components. The initial nursing assessment will closely follow the patient's admission to the unit and begin the evaluation. Two crucial determinations will be made: what the patient already knows about his illness and the educational priorities that need to be established. An estimation of the patient's ability to learn will be concordantly made. Because of subjectivity in personal assessment, a written objective test also will be given to the patient at the beginning of the program. Following clearly defined guidelines, the nurse will act as coordinator of the entire educational program. All contact with the patient will be used as an opportunity for gathering and giving information and reinforcing instruction.

The change or lack of change in a patient's behavior will serve as one of the primary indicators of successful completion of the program objectives. Decreased incidence of infection and hemorrhage and improved overall health are physical parameters that are easily recognized and would clearly indicate achievement of four of the stated objectives. This portion of the program evaluation will be conducted in the hospital by the staff and continued by the patient's physician when the patient returns home.

The patient's ability to define leukemia and understand his treatment, its actions and effects will be determined by employing two methods. Based on the nurses' contact with the patient during his initial and subsequent admissions, a comparison may be made with the original educational assessment. The patient, likewise, will be given an objective test following completion of the program. Contrasting this test with the test given prior to the initiation of the program will demonstrate quite readily if an increase in the patient's knowledge of his disease has occurred.

In order to evaluate the success or failure of the entire program, all new patients admitted to the unit will be exposed to the educational program.

Their knowledge of the disease and retention of the material will be compared with that of a control group of patients. The control group will be composed of patients who were admitted to the unit prior to the introduction of the educational program. An objective test will be given to these patients to compare the two groups.

Thus, the proposed evaluation will offer an appraisal of the program prior to its use on the unit, an estimation of the increase in the knowledge the patient has about leukemia after completing the program and a final comparison of the patients who have received systematic instructions with those who have had teaching without specific guidelines.

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Cancer Research Center
Columbia, Mo. 65201

Cervical Spinal Cord Trauma

(Continued from page 142)

Disposition

Finally, a word should be said in regard to the disposition of the patients incident to their departure. Of the 14 complete quadriplegics, seven (50%) returned to their homes and seven (50%) were transferred at different times to other facilities. There were 27 incomplete quadriplegics. Twenty-three (85%) returned to their homes. The family of one patient preferred his being admitted to a nursing home. Three were transferred to other rehabilitation facilities.

SUMMARY

The primary purpose of this study was to ascertain how successfully quadriplegic patients reached their goal of independent living in response to their hospital program of intensive recovery therapy.

Of the 45 patients, four had died during hospitalization, leaving a corrected total of 41. Those with complete cord lesions (14 cases or 34%), who had had no prospect of neurological recovery, were not rated. There were 27 cases (66%) having incomplete cord lesions. At the time of their hospital discharge, they were rated in the simplest of categories: *functional recovery status, independence status* and *dependence status.*

There were seven patients (26%) rated as having functionally recovered. Eleven patients (41%) became independent and nine (33%) remained in a dependent status. When the figures from the first two groups are combined, it is evident that 67% of the incomplete quadriplegics had realized their goal of independent living at the time of their discharge from the hospital.

Spinal cord injury has been a disease entity lowest in the list of medical priorities for centuries. Finally, however, the issue is being engaged. The several fronts of attack include (1) programs of basic research having to do with regeneration of the damaged or severed spinal cord, which problem is no longer considered to be insoluble, and (2) the important emphasis on the *immediate* care of the spinal cord-injured patient. There is little doubt about the success of this engagement.

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Reprints: Maurice B. Roche, M.D.
Research Section, Rehabilitation Center
St. John's Mercy Medical Center
615 S. New Ballas Rd.
St. Louis, Mo. 63141

Continuing Education Coming Events

March 18	**Adolescent Psychiatry for Physicians** (Four Tuesday evenings) Continuing Medical Education, Dept. of Psychiatry, St. Louis University Cardinal Glennon Memorial Hospital, St. Louis
March 18	**Children's Orthopedics: Differential Diagnosis of Internal Rotation of Lower Extremity of the Limping Child and Scoliosis** N.W. Mo. Chapter of MAFP and K.U. School of Medicine Moila Temple, St. Joseph
March 24-26	**Symposium: Surgery** Postgraduate Education K.U. Medical Center, Kansas City, Kan.
March 28-29	**The Long Weekend—Endocrinology and Diabetes Mellitus Workshop** M.U.-K.C. School of Medicine, K.C. Southwest Clinical Society and Academy of Health Professions Crown Center Hotel, Kansas City
April 2	**Seminar: Recognition and Management of Sexual Problems in Clinical Practice** The Ed Bixby Institute for Postgraduate Medical Education Research Hospital and Medical Center, Kansas City

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St. Louis Medical Society Auditorium
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All Members of the Profession Are Invited

Washington

(Continued from page 122)

legislation is a must, but most important of all, it must be sound, workable legislation. The people who have agreed to serve on this Advisory Panel are recognized experts on various issues which the Subcommittee will have to resolve and should contribute much to our work."

The list of panel members, however, was not immediately released.

Before the dust had settled from the skirmishing involved in the organization of the Congress, plans were being mapped for health legislative action. The House Commerce Subcommittee on Health is slated to take up quickly the two health bills vetoed late last year by President Ford providing aid for Nurses Training and the $1.8 billion measure authorizing community mental health centers, neighborhood health centers and the like.

Sen. Edward Kennedy, chief of the Senate Health Subcommittee, has introduced both bills in a single package and defied another veto. Not known is whether Congress will attempt to modify the measures to forestall a veto.

The House and Senate Health Subcommittee also are slated to take up early the Health Manpower measure which collapsed in the final days of the last session. The Administration is still working on a new proposal. Kennedy is expected to make another pitch for his sweeping bill requiring compulsory federal service for young physicians and the licensing and relicensing of physicians.

* * *

Medical liability is emerging as a hot topic on Capitol Hill this year. The Senate Health Subcommittee will hold mid-March hearings on a bill sponsored by Kennedy and Sen. Daniel Inouye (D-Hawaii) embodying a no-fault approach plus arbitration. A controversial section requires physicians who wish to be included under the program to have their practice reviewed by Professional Standards Review Organizations and reside in states with licensure and relicensure laws. Rep. Dan Rostenkowski, chairman of the Health Subcommittee of Ways and Means, has submitted a bill calling for a federal study of the problem. Sen. Gaylord Nelson (D-Wis.) has a bill establishing a federally administered program of reinsurance to protect companies against catastrophic claims.

***IMPORTANT INFORMATION:** This is a Schedule V substance by Federal law; diphenoxylate HCl is chemically related to meperidine. In case of overdosage or individual hypersensitivity, reactions similar to those after meperidine or morphine overdosage may occur; treatment is similar to that for meperidine or morphine intoxication (prolonged and careful monitoring). Respiratory depression may recur in spite of an initial response to Nalline® (nalorphine HCl) or may be evidenced as late as 30 hours after ingestion. LOMOTIL IS NOT AN INNOCUOUS DRUG AND DOSAGE RECOMMENDATIONS SHOULD BE STRICTLY ADHERED TO, ESPECIALLY IN CHILDREN. THIS MEDICATION SHOULD BE KEPT OUT OF REACH OF CHILDREN.*

Indications: Lomotil is effective as adjunctive therapy in the management of diarrhea.

Contraindications: In children less than 2 years, due to the decreased safety margin in younger age groups, and in patients who are jaundiced or hypersensitive to diphenoxylate HCl or atropine.

Warnings: Use with caution in young children, because of variable response, and with extreme caution in patients with cirrhosis and other advanced hepatic disease or abnormal liver function tests, because of possible hepatic coma. Diphenoxylate HCl may potentiate the action of barbiturates, tranquilizers and alcohol. In theory, the concurrent use with monoamine oxidase inhibitors could precipitate hypertensive crisis.

Usage in pregnancy: Weigh the potential benefits against possible risks before using during pregnancy, lactation or in women of childbearing age. Diphenoxylate HCl and atropine are secreted in the breast milk of nursing mothers.

Precautions: Addiction (dependency) to diphenoxylate HCl is theoretically possible at high dosage. Do not exceed recommended dosages. Administer with caution to patients receiving addicting drugs or known to be addiction prone or having a history of drug abuse. The subtherapeutic amount of atropine is added to discourage deliberate overdosage; strictly observe contraindications, warnings and precautions for atropine; use with caution in children since signs of atropinism may occur even with the recommended dosage.

Adverse reactions: Atropine effects include dryness of skin and mucous membranes, flushing and urinary retention. Other side effects with Lomotil include nausea, sedation, vomiting, swelling of the gums, abdominal discomfort, respiratory depression, numbness of the extremities, headache, dizziness, depression, malaise, drowsiness, coma, lethargy, anorexia, restlessness, euphoria, pruritus, angioneurotic edema, giant urticaria and paralytic ileus.

Dosage and administration: ***Lomotil is contraindicated in children less than 2 years old.*** Use only Lomotil liquid for children 2 to 12 years old. For ages 2 to 5 years, 4 ml. (2 mg.) t.i.d.; 5 to 8 years, 4 ml. (2 mg.) q.i.d.; 8 to 12 years, 4 ml. (2 mg.) 5 times daily; adults, two tablets (5 mg.) t.i.d. to two tablets (5 mg.) q.i.d. or two regular teaspoonfuls (10 ml., 5 mg.) q.i.d. Maintenance dosage may be as low as one fourth of the initial dosage. Make downward dosage adjustment as soon as initial symptoms are controlled.

Overdosage: Keep the medication out of the reach of children since accidental overdosage may cause severe, even fatal, respiratory depression. Signs of overdosage include flushing, lethargy or coma, hypotonic reflexes, nystagmus, pinpoint pupils, tachycardia and respiratory depression which may occur 12 to 30 hours after overdose. Evacuate stomach by lavage, establish a patent airway and, when necessary, assist respiration mechanically. Use a narcotic antagonist in severe respiratory depression. Observation should extend over at least 48 hours.

Dosage forms: Tablets, 2.5 mg. of diphenoxylate HCl with 0.025 mg. of atropine sulfate. *Liquid*, 2.5 mg. of diphenoxylate HCl and 0.025 mg. of atropine sulfate per 5 ml. A plastic dropper calibrated in increments of ½ ml. (total capacity, 2 ml.) accompanies each 2-oz. bottle of Lomotil liquid.

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When diarrhea has his number...

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Lomotil puts him back in the game.

Physicians and patients both want prompt control of the symptoms of diarrhea. A rapid, uncontrolled loss of fluids and electrolytes can cause a medical crisis, particularly in children, and in patients who are seriously ill, or in people who are badly undernourished.

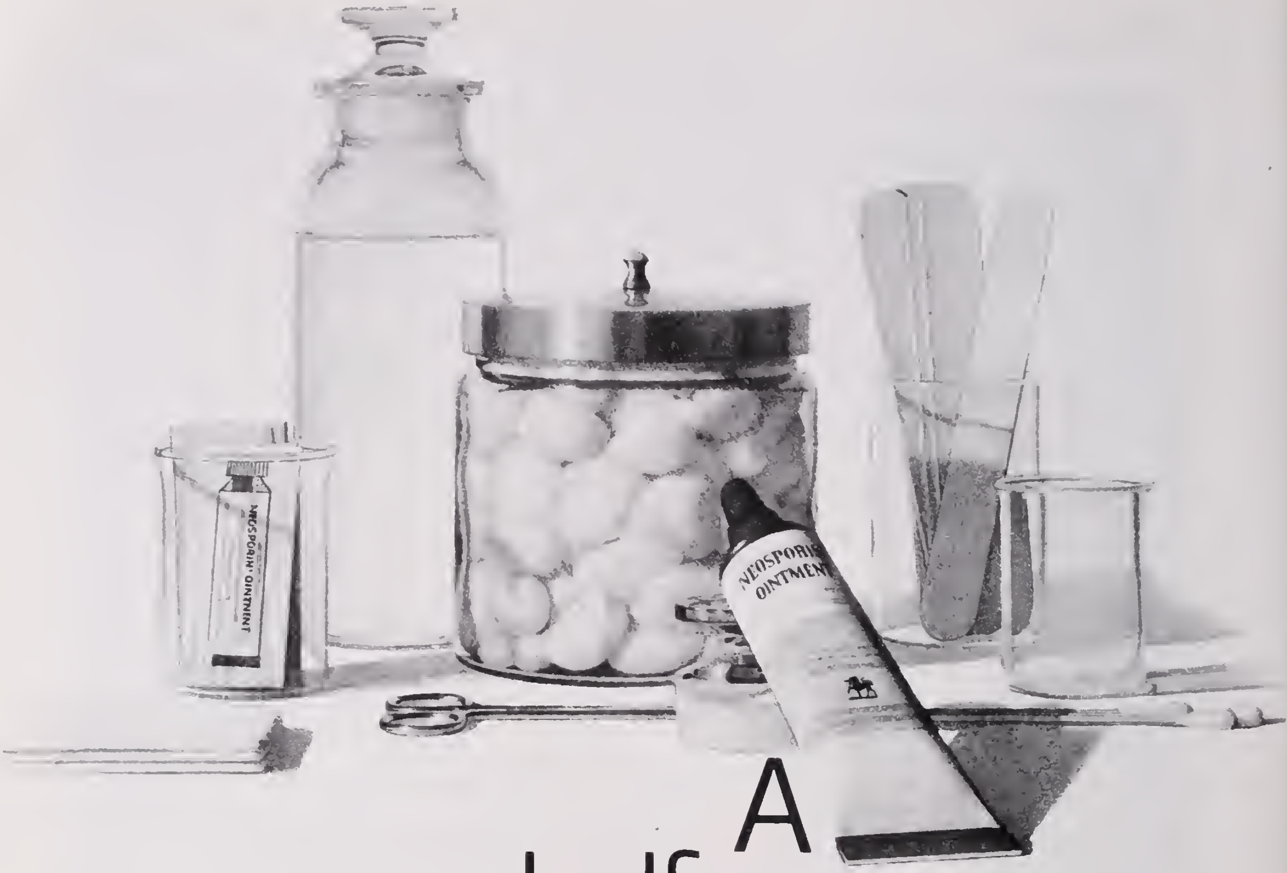
Lomotil usually stops diarrhea promptly. This rapid action halts the emergency aspect of diarrhea and is comforting and reassuring to the patient. Electrolyte and fluid losses can be corrected while the specific cause of the diarrhea is being determined. If an infective agent is the cause, appropriate antibiotic therapy should be given along with Lomotil.

Lomotil has few side effects, and those that do occur are generally mild.

Lomotil®
TABLETS/LIQUID

Each tablet and each 5 ml. of liquid contain:
diphenoxylate hydrochloride ...... 2.5 mg.
(Warning: May be habit forming)
atropine sulfate .... 0.025 mg.

Usually stops diarrhea promptly.



A
half-ounce
of prevention

Use it to prevent a topical infection. Or to treat one that's already started.
In either case, it's good medicine. Whether for lacerations,
burns, open wounds, IV catheter or surgical aftercare.
Neosporin® Ointment provides broad antibacterial coverage against common
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Each gram contains: Aerosporin® brand Polymyxin B Sulfate 5,000 units; zinc bacitracin 400 units;
neomycin sulfate 5 mg (equivalent to 3.5 mg neomycin base); special white petrolatum qs.
In tubes of 1 oz and 1/2 oz and 1/32 oz (approx.) foil packets.

INDICATIONS: *Therapeutically,* used as an adjunct to appropriate systemic therapy for topical infections, primary or secondary, due to susceptible organisms, as in: • infected burns, skin grafts, surgical incisions, otitis externa • primary pyodermas (impetigo, ecthyma, sycosis vulgaris, paronychia) • secondarily infected dermatoses (eczema, herpes, and seborrheic dermatitis) • traumatic lesions, inflamed or suppurating as a result of bacterial infection.

Prophylactically, the ointment may be used to prevent bacterial contamination in burns, skin grafts, incisions, and other clean lesions. For abrasions, minor cuts and wounds accidentally incurred, its use may prevent the development of infection and permit wound healing.

CONTRAINDICATIONS: Not for use in the eyes or external ear canal if the eardrum is perforated. This product is contraindicated in those individuals who have shown hypersensitivity to any of the components.

WARNING: Because of the potential hazard of nephrotoxicity and ototoxicity due to neomycin, care should be exercised when using this product in treating extensive burns, trophic ulceration and other extensive conditions where absorption of neomycin is possible. In burns where more than 20 percent of tl body surface is affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended.

PRECAUTIONS: As with other antibacterial preparations, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriat measures should be taken if this occurs.

ADVERSE REACTIONS: Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of pers allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section).

Complete literature available on request from Professional Services Dept. P

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Neither inconvenient potassium supplements nor special K^+ rich diets needed as a rule. Just 'Dyazide' once or twice daily for maintenance.

Two prime reasons patients drop out of hypertensive therapy are (1) the patient failed to understand directions, and (2) the regimen was overly complicated. Dosage is simple with 'Dyazide', easily understood, once or twice daily, depending on response. There's no need to complicate the regimen with potassium supplements or unwieldy potassium-rich diets.

Before prescribing, see complete prescribing information in SK&F literature or *PDR*. The following is a brief summary.

Indications: Edema associated with congestive heart failure, cirrhosis of the liver, the nephrotic syndrome; steroid-induced and idiopathic edema; edema resistant to other diuretic therapy. Also, mild to moderate hypertension.

Contraindications: Pre-existing elevated serum potassium. Hypersensitivity to either component. Continued use in progressive renal or hepatic dysfunction or developing hyperkalemia.

Warnings: Do not use dietary potassium supplements or potassium salts unless hypokalemia develops or dietary potassium intake is markedly impaired. Enteric-coated potassium salts may cause small bowel stenosis with or without ulceration. Hyperkalemia (>5.4 mEq/L) has been reported in 4% of patients under 60 years, in 12% of patients over 60 years, and in less than 8% of patients overall. Rarely, cases have been associated with cardiac irregularities. Accordingly, **check serum potassium during therapy, particularly in patients with suspected or confirmed renal insufficiency (e.g., elderly or diabetics). If hyperkalemia develops, substitute a thiazide alone.** If spironolactone is used concomitantly with 'Dyazide', **check serum potassium frequently**—both can cause potassium retention and sometimes hyperkalemia. Two deaths have been reported in patients on such combined therapy (in one, recommended dosage was exceeded; in the other, serum electrolytes were not properly monitored). Observe patients on 'Dyazide' regularly for possible blood dyscrasias, liver damage or other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving Dyrenium (triamterene, SK&F). Rarely, leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with the thiazides. Watch for signs of impending coma in acutely ill cirrhotics. Thiazides are reported to cross the placental barrier and appear in breast milk. This may result in fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly other adverse reactions that have occurred in the adult. When used during pregnancy or in women who might bear children, weigh potential benefits against possible hazards to fetus.

Precautions: Do periodic serum electrolyte and BUN determinations. Do periodic hematologic studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in post-sympathectomy patients. The following may occur: hyperuricemia and gout, reversible nitrogen retention, decreasing alkali reserve with possible metabolic acidosis, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), digitalis intoxication (in hypokalemia). Use cautiously in surgical patients. Concomitant use with antihypertensive agents may result in an additive hypotensive effect.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis; rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting (may indicate electrolyte imbalance), diarrhea, constipation, other gastrointestinal disturbances. Rarely, necrotizing vasculitis, paresthesias, icterus, pancreatitis, and xanthopsia have occurred with thiazides alone.

Supplied: Bottles of 100 capsules; in Single Unit Packages of 100 (intended for institutional use only).

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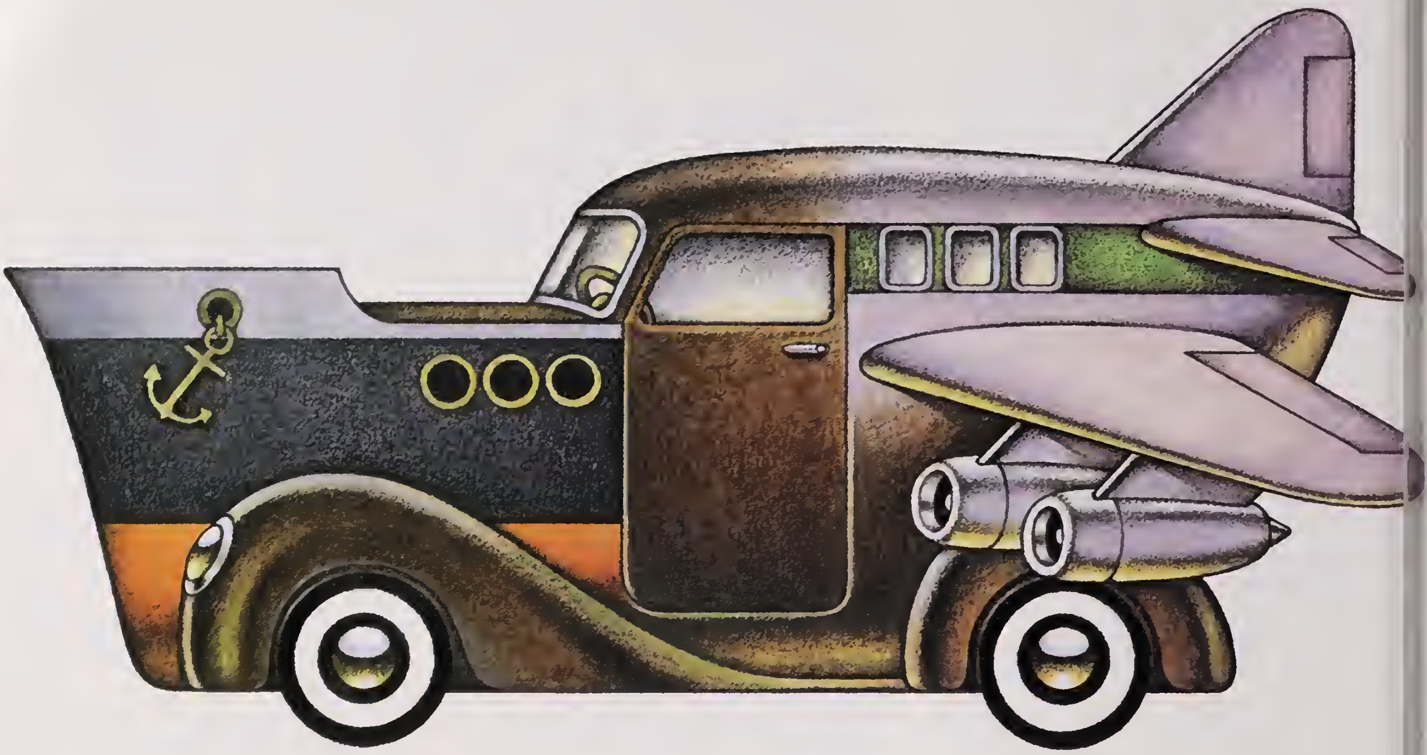

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Dosage: 25 to 50 mg. 1 hour before travel.

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BRIEF SUMMARY OF PRESCRIBING INFORMATION

CONTRAINDICATIONS. Administration of Antivert during pregnancy or to women who may become pregnant is contraindicated in view of the teratogenic effect of the drug in rats.

The administration of meclizine to pregnant rats during the 12-15 day of gestation has produced cleft palate in the offspring. Limited studies using doses of over 100 mg./kg./day in rabbits and 10 mg./kg./day in pigs and monkeys did not show cleft palate. Congeners of meclizine have caused cleft palate in species other than the rat.

Meclizine HCl is contraindicated in individuals who have shown a previous hypersensitivity to it.

WARNINGS. Since drowsiness may, on occasion, occur with use of this drug, patients should be warned of this possibility and cautioned against driving a car or operating dangerous machinery.

Usage in Children: Clinical studies establishing safety and effectiveness in children have not been done; therefore usage is not recommended in the pediatric age group.

Usage in Pregnancy: See "Contraindications."

ADVERSE REACTIONS. Drowsiness, dry mouth and, on rare occasions, blurred vision have been reported.

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Antivert®/25 Chewable Tablets
(meclizine HCl) 25 mg.
for motion sickness

President's Message

Yesterday, I received a letter from one of our members inquiring about the $60 assessment we have been asked to send to the AMA. It was a good letter that obviously was the result of some serious thought, and it demanded a thoughtful answer. I tried. There are some answers that I am unable to supply.

Why did the financial crisis hit so suddenly? Surely, it was something that the Board of Trustees should have seen coming down the road. Apparently, the AMA was all but broke before anyone knew it.

James C. Cope, M.D.

Why does the AMA still publish "Prism" at $1 million a year and cut back on some important physician services? This point was debated by the House of Delegates.

Why, in this time of political turmoil, was it suggested that the Washington office be closed and the field services be cut back?

I sat through the reference committee hearings and now have only a little better idea of what is going on than I had before I went to Portland.

We all know what inflation has done to everybody and everything during the past few years. In the final analysis, it seems that the greatly increased costs of printing and distributing was the cause of the trouble. The House of Delegates seemed to be like our national congress. It would not follow the recommendations of the Board of Trustees nor would it authorize meaningful reductions in expenditures. Some group was ready to stand up and testify to the absolute need of every publication, pamphlet and leaflet that is published. (By volume, the AMA is the largest publishing house in the United States.)

It is clear that the House of Delegates wants to have its cake and eat it too. This can be done, but we will have to pay for it.

A compromise was reached. The House of Delegates voted a $60 assessment instead of the $90 dues increase that was requested by the Board of Trustees. It also appointed a committee of the House to investigate the situation and to report to the House at the next meeting.

Meanwhile, what are we going to do? Here is what I think.

Allowing the AMA to be seriously hobbled by lack of funds right now when we need the AMA the most is unthinkable. I sent in my $60.

The AMA is the only voice we physicians have on the national scene and we need it badly. Even though I suspect that mismanagement or, at least, poor judgment is the cause of some of our trouble, I fail to see how withholding the assessment is going to help the individual doctor or improve our image with the federal government. Because I consider this the overriding consideration, I sent in my $60.

(Continued on next page)

I believe the AMA should shift its emphasis from education and public service to political activity and legislative development. At least, it should be more active in these areas. Because this cannot be done with a dead AMA, I sent in my $60 and will make my opinion known to the AMA delegates from Missouri.

In spite of the fact that there are only a few doctors in the state who will be hurt by the assessment, I feel that we have been taken. I hope our delegates to the AMA will have received some pretty definite instructions from their constituents before the House convenes in Atlantic City this spring.

Attend the Outstanding Scientific Program in St. Louis!

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Woman's Auxiliary

50th Anniversary

Hi! Ho! Come to the Convention!

All members of the Missouri State Medical Association are cordially invited to join the Woman's Auxiliary for breakfast on the Starlight Roof on Saturday, April 19, during the Annual Session at the Chase-Park Plaza Hotel in St. Louis.

This is not the usual, run-of-the-mill type of breakfast. It is a special Public Affairs Breakfast sponsored by our MMPAC and Public Affairs Committee. The speaker will be Frank J. Jirca, Jr., M.D. of Berwyn, Ill., a member of the AMA Board of Trustees. Among other subjects, Dr. Jirca will discuss the impact of MMPAC.

Under the leadership of Mrs. James A. Reid of Marshall, chairman, the Auxiliary's MMPAC Committee has done an outstanding job of recruiting members. The Auxiliary is proud of the fact that 80 of its members have joined MMPAC and that 12 are sustaining members. This represents a very respectable proportion of the Missouri PAC members.

The breakfast is just one of the exciting events which will be a part of our 50th Annual Convention. Mrs. Hoyt Gardner of East Hampton, Conn., First Vice-President of the Woman's Auxiliary to the AMA, will be our special guest and the keynote speaker for a workshop for all incoming officers.

Mrs. George J. Lytton
President

The workshop will be conducted by Mrs. William R. McPhee of Kansas City, President-Elect of the MSMA Auxiliary, whose theme for the workshop is "Program Projections for 1975-1976" or "Our Auxiliary Forecast for the Bicentennial Year." This program projection is being presented at the request of members who attended the convention last year and found it helpful to receive this information at the Convention. It provides a solid foundation for programs for the county auxiliaries in the coming year.

Another highlight of every convention is the presentation of the County Auxiliary Presidents' reports. Actually, this is the "report card" for the year. Awards are presented in several categories. Donations to the Missouri State Medical Foundation, AMA-ERF participation and growth in membership will be suitably recognized.

Increasing our members has been the most important ongoing project this year. We hope that if you know a doctor's wife who is not an Auxiliary member, you will encourage her to join us.

Our goal is a 10% increase in membership for the year. We need everyone's help to attain it.

Meet You in St. Louis!

EDITORIAL

LAWYER'S OBSERVATIONS ON MALPRACTICE PROBLEM

By Lon Hocker

(Mr. Hocker is a former president of the American College of Trial Lawyers and a former president of the Bar Association of St. Louis.)

Here are some thoughts on the medical malpractice problem which has been the subject of much concern in *The Globe-Democrat* recently.

These suits are a problem because our present judicial system has made it so: The odds are grossly in favor of the claimant.

1. The claimant can't lose—the law permits him to hire a lawyer on a contingency, i.e. for one-fourth, or one-third or one-half of the recovery. This means the claimant can't be out of pocket for an attorney's fee. Not so the defendant doctor or hospital, or, what is the same thing, the doctor's or hospital's insurance company. The defendant cannot hire on a contingency basis, and must pay the defense lawyer's fee WIN or LOSE.

Cure: In England and Canada attorney's fees are awarded to the winning party as part of his court costs. This does no more than put the defendant back where he was when the suit was filed, if he wins the case, instead of a couple of thousand dollars in the hole. That is merely, simple justice. On the other hand, it makes a claimant think twice before filing a long-shot case with a view to getting a nuisance settlement.

* * *

2. In case of a serious injury or bad result, the probable fee to the claimant's lawyer far surpasses what a lawyer could ever charge on a time-spent basis. One third of a million dollars is $333,333. For a fee in this order of magnitude the most aggressive and most prosperous lawyer can afford to gamble his time; and the temptation to cut a corner to win is inherent in the arrangement. The lawyer, having an interest in the outcome, becomes, to that extent, a co-plaintiff. He can afford to seek out and hire the most pliable of expert witnesses, and advance these costs for his client's account, knowing full well he will not be able to collect the account if the case is lost: A de facto barratry.

Cure: The original Canons of Ethics of the American Bar Association formerly provided "Where contingent fees are allowed by law, they shall be under the supervision of the court." Contingent fees are not allowed in Canada. Where they are allowed, this canon would mean, if readopted by our Supreme Court, that the court may cut the agreed contingency down to 10 per cent, 5 per cent, or whatever is reasonable considering the responsibility assumed and the time spent by the lawyer. One measure of reasonableness might be the normal per-hour charge, doubled, to take account of the cases in which no fee is collectible.

* * *

3. Why, in the final analysis, must a group of 12 randomly-selected citizens in a jury box be allowed to second-guess a doctor with eight or 10 years of medica training?

It is generally supposed among lawyers that an express pre-treatment waiver of the right to claim medica malpractice would be against public policy and void and Missouri still holds to the ancient common-law rule that arbitration agreements are voidable at the wil of either party.

Cure: We could (as other states have done) abolish the common law rule and permit binding contracts to arbitrate. This would permit doctors and hospitals to require as a precondition to treatment, that the patien agree to arbitrate any claim he might wish to make for medical malpractice, each side picking one arbitrato and they together picking the third, a medical doctor skilled in the medical field involved in the case.

There is nothing scary about this. Nearly every union management contract contains a provision for binding arbitration of unresolved employment grievances. This is binding in Missouri because of an express authorization in the federal Taft-Hartley law, and everybody likes it.

It is hard for Mr. John Q. Public to realize that it i he, not some distant rich and impersonal insurance company, who ultimately has to pay these big judgments, in the form of increased medical costs for his own care.

St. Louis Globe-Democrat
Jan. 30, 1975
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County Society News

FIRST DISTRICT

COUNCILOR
JOHN N. MARTIN, ST. JOSEPH

Buchanan County Medical Society

Fifty-five members attended the annual "Heart" program of the Buchanan County Medical Society on February 5.

Dr. Ben D. McCallister, cardiologist from Kansas City, presented an address on "Has Coronary Artery Surgery Affected the Natural History of Coronary Heart Disease?—Late Results and Long-Term Follow-Up." The lecture followed dinner and a meeting at Moila Club in St. Joseph.

Dr. McCallister noted that the four leading causes of coronary disease are hypertension, tobacco, obesity and elevated cholesterol. He cited scientific evidence of heavy smokers being three times as likely to have heart disease as nonsmokers. He traced the history of coronary bypass surgery, noting the increasingly good results now being obtained.

The speaker pointed out that surgeons have now developed low-risk bypass operations and he is optimistic about future developments in which presently high-risk patients could undergo the bypass surgery successfully.

Dr. Robert R. Stuber introduced the speaker. Arrangements for the meeting were made by members of the Program Committee who are Dr. Edward H. Andres, chairman; Dr. Stuber and Dr. Wallace McDonald.

Dr. William B. O'Connor, President, presided at the session.

Carl K. Ness, M.D., *Secretary*

SECOND DISTRICT

COUNCILOR
LYSLE M. BACH, M.D., HANNIBAL

Chariton-Macon-Monroe-Randolph County Medical Society

The Chariton-Macon-Monroe-Randolph County Medical Society met on January 13 in the Library Conference Room at Woodland Hospital in Moberly.

Several communications from the Missouri State Medical Association were presented and there was discussion concerning the proposed bylaws changes. Proceedings for the AMA House of Delegates and at the Missouri Council meetings also were presented.

The program for the evening consisted of "Case Presentations" by members of the Society and included several reports of cases of intestinal neoplasm and follow-up as well as a case of femoral artery embolus. Dr. Tom Fleming presented a discussion of various types of heart blocks.

Members attending were Drs. F. L. Harms, Salisbury; James Campbell and D. E. Eggleston, Macon; F. L. Barnett, Paris; P. V. Dreyer, Huntsville; J. Baker, R. L. Bautista, W. D. Chute, C. C. Cohrs, T. S. Fleming, L. E. Huber, G. R. Hudson, R. V. Tompson and Robert Young, Moberly.

EIGHTH DISTRICT

COUNCILOR
HOWARD J. McALHANY, M.D.,
SPRINGFIELD

Ozarks Medical Society

The Ozarks Medical Society met in the home of Dr. Francisco R. Esparrago in Monett on January 14.

The program was presented by Dr. Francis Maple of Springfield. His subject was the diagnosis of Chronn's disease.

During the business meeting, the matter of elimination of volunteer members in the AMA was discussed. It was moved that the Society be against compulsory membership in the AMA. The motion passed unanimously.

There being no further business, the meeting was adjourned.

A. J. Graves, M.D., *Secretary*

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MISSOURI MEDICINE
keeps you informed
and helps pay the
publishing costs!
When the local
representative calls,
tell him you saw
his company's ad in
your journal.

ANNOUNCING

BURDICK-MUNNS MEDICAL SUPPLY CO.

ELECTROCARDIOGRAPH
TECHNICAL TRAINING
PROGRAM

TOPEKA, KANSAS .... APRIL 4, 1975
KANSAS CITY, MISSOURI .... APRIL 11, 1975
WICHITA, KANSAS .... APRIL 4, 1975
ST. LOUIS, MISSOURI .... APRIL 4, 1975

8:00 A.M.
To
5:00 P.M.

Please call Bud Lowe or Mike Warnstaff in Topeka, Kansas for your reservations
913-272-2300

A demonstration of Stress Monitoring will be included at the end of each day

MUNNS
MEDICAL
SUPPLY

New Members

Nancy L. Abdou, M.D., 2411 Holmes, Kansas City, has become a member of Jackson County Medical Society. Dr. Abdou is a native of Iola, Kan., received her preliminary education at Kansas University and her M.D. degree at Kansas University in 1965. She specializes in hematology.

Rushdy Abadir, M.D., 807 Stadium, Columbia, has become a member of Boone County Medical Society. Dr. Abadir is a native of Cairo, received his preliminary education at Ibrehimiah School and his M.D. degree at Cairo University in 1951. He specializes in radiation oncology.

Donald P. Alderman, M.D., 751 E. 63rd, Kansas City, has become a member of Jackson County Medical Society. Dr. Alderman is a native of Syracuse, N. Y., received his preliminary education at Yale University and his M.D. degree at State University of New York in 1969. He specializes in anesthesiology.

Asa Barnes, Jr., M.D., Ellis Fischel Cancer Hospital, Columbia, has become a member of Boone County Medical Society. Dr. Barnes is a native of Cape Girardeau, received his preliminary education at the University of Kentucky and his M.D. degree at Yale University in 1959. He specializes in pathology.

Alvin Beers, Jr., M.D., 637 Fieldcrest, St. Louis, has become a member of St. Louis Medical Society. Dr. Beers is a native of Kansas, received his preliminary education at Kansas University and his M.D. degree at Kansas University in 1972. He specializes in internal medicine.

Martin J. Bell, M.D., 500 S. Kingshighway, St. Louis, has become a member of St. Louis Medical Society. Dr. Bell is a native of New York, received his preliminary education at New York University and his M.D. degree at the State University of New York in 1963. He specializes in pediatric surgery.

Stephen D. Burrows, M.D., 510 S. Kingshighway, St. Louis, has become a member of St. Louis Medical Society. Dr. Burrows is a native of Illinois, received his preliminary education at the University of Illinois and his M.D. degree at Washington University in 1974. He is an intern in radiology.

Homero Camacho, M.D., 240 Rockhill Medical Bldg., Kansas City, has become a member of Jackson County Medical Society. Dr. Camacho is a native of Colombia, S.A., received his preliminary education at the National Institute of Colombia, and his M.D. degree at the National University of Colombia in 1966. He specializes in obstetrics and gynecology.

Ramon V. Canent, Jr., M.D., 24th and Gillham Rd., Kansas City, has become a member of Jackson County Medical Society. Dr. Canent is a native of the Philippines, received his preliminary education at Santo Tomas University and his M.D. degree at Santo Tomas University in 1957. He specializes in cardiology pediatrics.

Suhra T. Chaudhuri, M.D., 4950 Cherry, Kansas City, has become a member of Jackson County Medical Society. Dr. Chaudhuri is a native of India, received his preliminary education at Lady Brabourne College and his M.D. degree at Calcutta Medical College in 1961. He specializes in obstetrics and gynecology.

William Cone, M.D., 549 N. Taylor, Kirkwood, has become a member of Mid-Missouri County Medical Society. Dr. Cone is a native of Grand Rapids, Mich., received his preliminary education at Yale University and his M.D. degree at Yale University in 1954. He specializes in psychiatry.

Richard Escoffery, M.D., 4989 Barnes Hospital Plaza, St. Louis, has become a member of St. Louis Medical Society. Dr. Escoffery is a native of Jamaica and received his M.D. degree at the University of West Indies in 1969. He specializes in ophthalmology.

Felix D. Fortin, III, M.D., 4320 Wornall Rd., Kansas City, has become a member of Jackson County Medical Society. Dr. Fortin is a native of Kansas City, received his preliminary education at the University of Notre Dame and his M.D. degree at the University of Kansas in 1970. He specializes in radiology.

Jorge Gabilondo, M.D., Medical College of Georgia, Augusta, Ga., has become a member of St. Louis Medical Society. Dr. Gabilondo is a native of Peru, received his preliminary education at San Marcos University and his M.D. degree at

San Marcos University in 1971. He specializes in internal medicine and gastroenterology.

James C. Hawkins, M.D., 806 Stadium, Columbia, has become a member of Boone County Medical Society. Dr. Hawkins is a native of Omaha, Neb., received his preliminary education at the University of Missouri and his M.D. degree at Washington University in 1949. He is in general practice.

Syed A. Husain, M.D., 807 Stadium, Columbia, has become a member of Boone County Medical Society. Dr. Husain is a native of Delhi, India, received his preliminary education at D. J. Science College and his M.D. degree at Dow Medical College in 1962. He specializes in psychiatry.

Savitri Jain, M.D., 1515 Lafayette, St. Louis, has become a member of St. Louis County Medical Society. Dr. Jain is a native of New Delhi, India, received his preliminary education at the Hindu College and his M.D. degree at Lady Hardinge College in 1958. He specializes in internal medicine.

Carl G. Kardinal, M.D., Business Loop 70 & Garth, Columbia, has become a member of Boone County Medical Society. Dr. Kardinal is a native of Downey, Calif., received his preliminary education at California State College and his M.D. degree at Washington University in 1965. He specializes in hematology, oncology, and internal medicine.

In Memoriam

James R. Compton, M.D., 5632 America Dr., Sarasota, Fla., a graduate of the College of Physicians and Surgeons, 1914; member of St. Louis County Medical Society; age 85; died Nov. 29, 1974.

William W. Buckingham, M.D., 310 W. 49th, Kansas City, a graduate of the University of Pennsylvania, 1926; member of Jackson County Medical Society; age 72; died Dec. 30, 1974.

Samuel E. Senor, M.D., 722½ Francis, St. Joseph, a graduate of Jefferson Medical College, 1925; member of Buchanan County Medical Society; age 78; died Jan. 11, 1975.

Cecil G. Leitch, M.D., Rt. #2, Box 222, Blue Springs, a graduate of the University of Kansas, 1927; member of Jackson County Medical Society; age 72; died Jan. 15, 1975.

Paul Murphy, M.D., 1035 Bellevue, St. Louis, a graduate of St. Louis University, 1926; member of St. Louis Medical Society; age 73; died Jan. 28, 1975.

PRESCRIBING INFORMATION
Antiminth (pyrantel pamoate) Oral Suspension

Actions. Antiminth (pyrantel pamoate) has demonstrated anthelmintic activity against *Enterobius vermicularis* (pinworm) and *Ascaris lumbricoides* (roundworm). The anthelmintic action is probably due to the neuromuscular blocking property of the drug.

Antiminth is partially absorbed after an oral dose. Plasma levels of unchanged drug are low. Peak levels (0.05-0.13μg/ml.) are reached in 1-3 hours. Quantities greater than 50% of administered drug are excreted in feces as the unchanged form, whereas only 7% or less of the dose is found in urine as the unchanged form of the drug and its metabolites.

Indications. For the treatment of ascariasis (roundworm infection) and enterobiasis (pinworm infection).

Warnings. *Usage in Pregnancy:* Reproduction studies have been performed in animals and there was no evidence of propensity for harm to the fetus. The relevance to the human is not known.

There is no experience in pregnant women who have received this drug.

Precautions. Minor transient elevations of SGOT have occurred in a small percentage of patients. Therefore, this drug should be used with caution in patients with pre-existing liver dysfunction.

Adverse Reactions. The most frequently encountered adverse reactions are related to the gastrointestinal system.

Gastrointestinal and hepatic reactions: anorexia, nausea, vomiting, gastralgia, abdominal cramps, diarrhea and tenesmus, transient elevation of SGOT.

CNS reactions: headache, dizziness, drowsiness, and insomnia. Skin reactions: rashes.

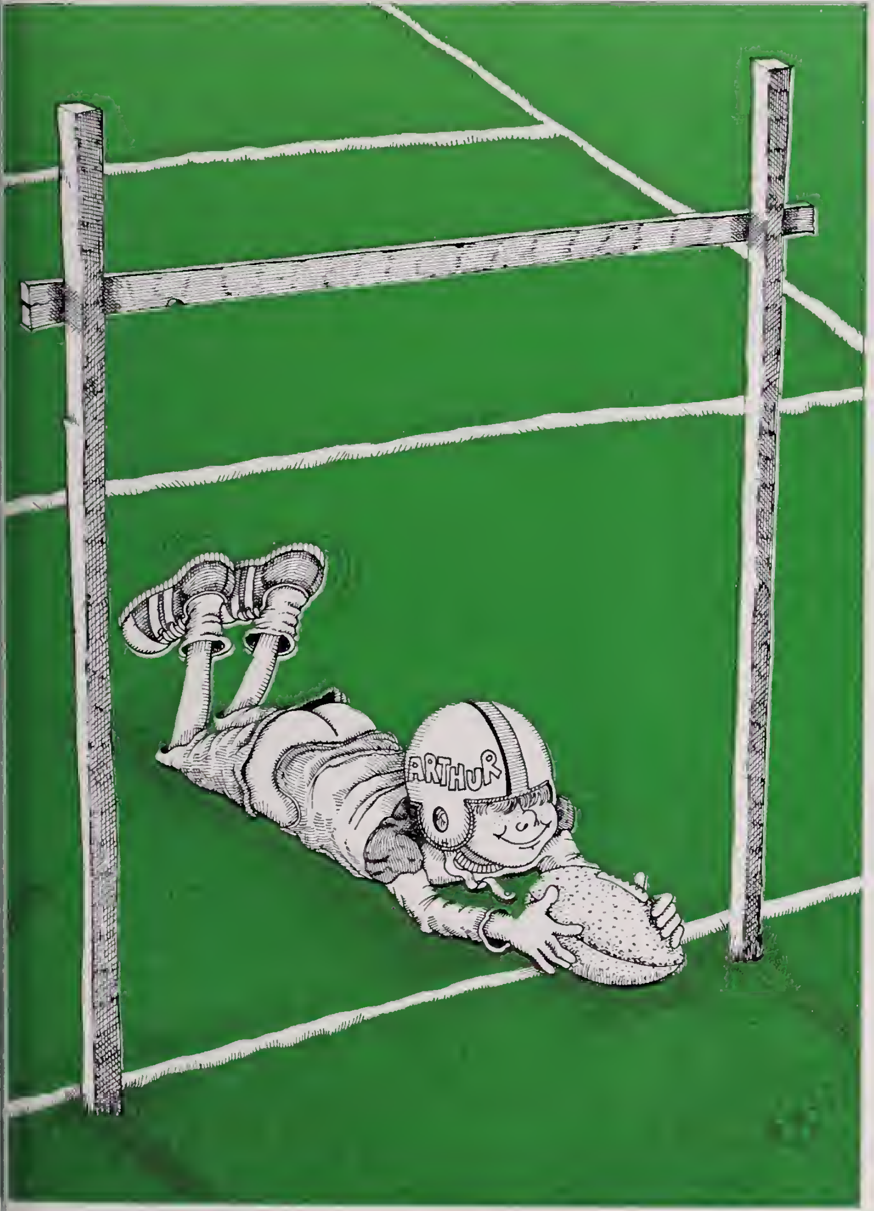
Dosage and Administration. *Children and Adults:* Antiminth Oral Suspension (50 mg. of pyrantel base/ml.) should be administered in a single dose of 11 mg. of pyrantel base per kg. of body weight (or 5 mg./lb.); maximum total dose 1 gram. This corresponds to a simplified dosage regimen of 1 cc. of Antiminth per 10 lb. of body weight. (One teaspoonful = 5 cc.)

Antiminth (pyrantel pamoate) Oral Suspension may be administered without regard to ingestion of food or time of day, and purging is not necessary prior to, during, or after therapy. It may be taken with milk or fruit juices.

How Supplied. Antiminth is available as a pleasant tasting caramel-flavored suspension which contains the equivalent of 50 mg. pyrantel base per ml., supplied in 60 cc. bottles and Unitcups™ of 5 cc. in packages of 12.

ROERIG Pfizer
A division of Pfizer Pharmaceuticals
New York, New York 10017

WORMS BLITZED



A single dose of Antiminth (1 cc. per 10 lbs. of body weight, 1 tsp./50 lbs.—maximum dose, 4 tsp.=20 cc.) offers highly effective control of *both* pinworms and roundworms.

Antiminth has been shown to be extremely well tolerated by children and adults alike in clinical studies.* Pleasantly caramel-flavored, it is non-staining to teeth and oral mucosa on ingestion... doesn't stain stools, linen or clothing.

One prescription can economically treat the entire family.

ROERIG Pfizer
A division of Pfizer Pharmaceuticals
New York, New York 10017

Pinworms, roundworms controlled with a single, non-staining dose of

ANTIMINTH®

(pyrantel pamoate)

equivalent to 50 mg. pyrantel/ml.

ORAL SUSPENSION

on file at Roerig.

Please see prescribing information on facing page.

FINANCIAL STATEMENT FOR THE YEAR 1974

LENNERTSON & COMPANY
Certified Public Accountants
ST. LOUIS, MISSOURI 63144

January 29, 1975

Missouri State Medical Association
113 Madison
Jefferson City, Missouri 65101

Gentlemen:

A review was made of the accounts of the Missouri State Medical Association, a non-profit Missouri corporation, for the year 1974, and a report thereon is presented together with the following exhibits:

Exhibit A	Balance Sheet
Exhibit B	Income Statement
Exhibit C-1	Statement of Commissions and Meeting Expenses
Exhibit C-2	Statement of Investments
Exhibit D	Dues Receivable and Memberships by Societies

It should be noted that members' dues and investment income are taken into income on the cash receipt basis whereas the other accounts are maintained on the accrual basis. Rentals received in advance for Annual Session exhibit space and advance contributions are shown as prepaid and carried forward to the year to which they apply.

Scope of Examination

The Balance Sheet at December 31, 1974 and the Income Statement for the year then ended were reviewed. Examinations or tests were made of the accounting records, in the manner and to the extent deemed appropriate, without making a detailed audit of the transaction.

Recorded cash receipts for the year were traced in total into the bank as deposits and disbursements for the period were substantiated by an inspection of paid checks, purchase invoices and other data on file.

Selective tests were made of the income and expense accounts for the period. It was noted that space in the Journal was contributed to the United States Treasury Department for bond advertising, to members for small classified ads, and to public service organizations.

Income Statement

The financial result of activities of the Association for the year 1974 was an excess of expenses over income of $316.79 as set forth in Exhibit B.

Balance Sheet

The financial position of the Association at December 31, 1974 is presented in Exhibit A. Comments on the larger balance sheet accounts follow:

Cash in banks, as shown by the books, was reconciled to the regular monthly bank statements and confirmations received from the depositories. The petty cash fund was verified by physical count.

Permanent investments with a cost of $80,454.09 and the Certificates of Deposit were confirmed by a statement from the custodian, Mercantile Trust Co. Investment income for the year was as follows:

Interest—Certificates of Deposit	$14,520.98
Interest—Corporate Bond	225.00
Dividends on Stock	3,433.45
Total Investment Income	$18,179.43

Accounts Receivable-Advertisers of $2,760.85 represent the unpaid balance due from Journal advertisers. Of this amount $2,571.85 was due from the State Journal Advertising Bureau as follows:

December, 1974	$ 912.98
November, 1974	1,505.87
Prior to November, 1974	153.00
Total	$2,571.85

In January, 1975, a check was received paying $2,032.43 of the November and prior accounts.

Unpaid dues of $7,202.50, offset by a reserve account in like amount, represents 1974 dues of delinquent members carried at the request of local Societies. Other delinquent members were dropped from membership in accordance with the by-laws. Exhibit D presents a summary of unpaid dues and membership by Societies, as shown by the records of the Association.

The building occupied by the Association with a cost of $116,431.52 will be depreciated over a useful life of 30 years and the furniture and fixtures in the amount of $20,637.04 has a 10 year useful life. Yearly depreciation will not be included as an expense, but depreciation less principal mortgage payments, will be recorded as a reduction to "Reserve for Future Activities."

Purchases of small equipment, rentals and repairs for the year in the sum of $3,725.68 were charged to expense in lieu of depreciation.

The records were carefully reviewed for liabilities at December 31, 1974 and it is believed that all current liabilities of substantial amount are included in the Balance Sheet.

Exhibitors have made advance payments of $4,345.00 for annual session exhibit space and these payments will be taken into income when earned in 1975.

The real estate mortgage due Mercantile Mortgage Co. is for a term of 15 years at 7% interest with monthly payments of $647.16 including interest. The loan balance at December 31, 1974 is $68,696.31.

The excess of assets over liabilities in the amount of $208,833.26 is shown in the Balance Sheet as a "Reserve for Future Activities."

General

During the year, payments were made to and for the following sponsored organizations:

Missouri State Medical Association Pension Fund	
Employees' Retirement Insurance Pension	$ 6,384.62
Employees' Pension Plan Contribution	23,410.80
Total	$29,795.42

The Association paid administrative and educational expenses for Missouri Medical Political Action Committee in the amount of $2,850.16 during the year ended December 31, 1974.

Collections for the American Medical Association and the Missouri State Medical Foundation are made along with the Missouri State Medical Association annual dues. Below is a schedule of dues and assessments for each member in effect during the year 1974.

	Active	*Junior*
Journal	$ 3.00	$ 3.0
Association General Fund	62.00	7.0
Foundation Assessment	10.00	—
Missouri State Medical Association— Dues and Assessments	$ 75.00	$10.0
American Medical Association	110.00	20.0
Totals	$185.00	$30.0

Except for $155.00, the 1974 collections of $40,200.00 for the Missouri State Medical Foundation have been remitted along with $5.00 due from the year 1973. The $110 per Active member and $20 per Junior member collected for the A.M.A. totaling $364,925.0 has been remitted.

Insurance policies were inspected and the following general insurance was in force at the close of the year:

Insurance on	*Type of Coverage*	*Amoun*
Building	Fire and Extended Coverage (90% co-ins)	$110,00
Land and Building	Title Insurance	$125,00
Liability	Bodily Injury and Property Damage Liability	$300,000/300,00
Liability	Premise Medical Payment	$500/10,00
Furniture and Fixtures	Fire and Extended Coverage	$15,00
Employees	Workmen's Compensation	Statutor
President, Executive Secty., Office Manager, Bookkeeper Stenographer	Fidelity Bond	$10,00
Treasurer	Fidelity Bond	$20,00
Journal Publication	Publisher's Liability ($2,500 deductible)	$500,00
Journal Publication	Advertisers' Libel ($2,500 deductible)	$500,00
Automobiles of Employees on M.S.M.A. business	Non-ownership— Bodily Injury	$100,000/300,00
	Non-ownership— Property Damage	$25,00
Members and Auxiliary Members on M.S.M.A. business under age 70	Travel Accident (away from home)	$25,000/250,00 $500 Medical Expens

Subject to the comments thereon, the attached statements, in ou opinion fairly present the financial position of the Missouri Stat Medical Association at December 31, 1974, and the result of th activities for the year then ended. The records for the year were kep in accordance with accepted principles of accounting applied on basis consistent with that of the preceding year.

Yours very truly,
Lennertson & Co.
Certified Public Accountants

Exhibit

Missouri State Medical Association
Balance Sheet, December 31, 1974

Assets

Cash		
Mercantile Trust Co. (Treasurer's Account)	$ 10,462.36	
Central Missouri Trust Co. (Secretary's Account)	872.17	
Petty Cash Fund	25.00	
Certificate of Deposit	40,000.00	$ 51,359.5
Investments at Cost (Exhibit C-2)		
Corporate Bond	$ 5,000.00	
Corporation Stocks	75,454.09	
Total (Market Value $71,593.25)		$ 80,454.0

Accounts Receivable		
Advertisers	$ 2,760.85	
Others	1,033.68	$ 3,794.53
Dues Receivable—Exhibit D (See Reserve-Contra)		$ 7,202.50
Fixed Assets (At cost)		
Pledge on Mortgage Payable		
Land	$ 26,000.00	
Building	116,431.52	
Furniture and Fixtures	20,637.04	
Total	$163,068.56	
Less Reserve for Depreciation	9,913.26	$153,155.30
Advance for Travel Expense		$ 1,220.99
		$297,186.94

Liabilities

Accounts Payable		
Supplies and Expenses	$ 7,479.87	
Due Missouri State Medical Foundation	155.00	$ 7,634.87
Deferred Credit to Income		
Advance Payment by Exhibitors for 1975 meeting	$ 4,345.00	
Advance Contributions—Annual Meeting	275.00	
Deposit	200.00	$ 4,820.00
Reserve for Uncollected Dues		$ 7,202.50
Real Estate Mortgage (payable $647.16 per month including interest)		$ 68,696.31
Reserve for Future Activities		
Balance 1/1/74	$215,494.64	
Depreciation less Principal Mortgage Payments	(3,099.91)	
Loss on Sale of Investments	(3,244.68)	
Excess of Expenses Over Income—Exhibit B	(316.79)	$208,833.26
		$297,186.94

Exhibit B

Missouri State Medical Association
Income Statement, for the Year 1974

Particulars	*General Activities*	*Journal Publication*	*Total*
Dues Received (including $3.00 per member annually for the Journal)	$250,194.00	$12,471.00	$262,665.00
Rentals—Annual Session Exhibit Space	8,855.00		8,855.00
Annual Session Contributions	1,475.00		1,475.00
Subscriptions to the Journal—Nonmembers		1,192.40	1,192.40
Advertising Space—The Journal		28,831.35	28,831.35
nvestments—Interest and Dividends	18,179.43		18,179.43
Collection Fees on A.M.A. Dues	6,782.57		6,782.57
Tour Reimbursement	3,046.10		3,046.10
Reimbursed Fees for Services	6,845.02		6,845.02
Total Income	$295,377.12	$42,494.75	$337,871.81
Expenses			
alaries	$127,206.92	$18,890.08	$146,097.00
The Journal—Paper, Printing, etc.		41,671.92	41,671.92
Cash Discount to Advertisers		354.90	354.90
Commission on Journal Advertising		4,584.10	4,584.10
Auto Expense	386.74		386.74
Commission and Meeting Expense	56,046.40		56,046.40
Custodian Fees—Investments	278.93		278.93
Dues and Subscriptions	830.26		830.26
Employees' Pension Plan Contribution	26,249.76	3,545.66	29,795.42
Equipment Purchases, Rentals and Repairs in lieu of Depreciation	3,121.58	604.10	3,725.68
nsurance—General	1,094.00		1,094.00
nsurance—Blue Cross	2,151.89	425.24	2,577.13
nterest Expense	4,917.88		4,917.88
MMPAC Administrative and Educational Expense	2,850.16		2,850.16
Mortgage Principal Payments	2,848.04		2,848.04
Occupancy Expense	3,075.11	645.08	3,720.19
Postage	4,479.76		4,479.76
Professional Fees	4,742.35	600.00	5,342.35
Stationery, Printing and Office Supplies	4,284.46		4,284.46
tudent Awards	225.00		225.00
Taxes—Payroll	6,204.71	1,130.68	7,335.39
Taxes—Other	1,689.60		1,689.60
Taxes—Real Estate	654.90		654.90
Telephone and Telegraph	6,107.10	1,206.80	7,313.90
Traveling Expenses—Executive Secretary and Assistants	5,084.55		5,084.55
Total Expenses	$264,530.10	$73,658.56	$338,188.66
Excess of (Expense) or Income	$ 30,847.02	($31,163.81)	$ (316.79)

Exhibit C-1

Missouri State Medical Association
Statement of Commissions and Meeting Expenses
for the Year 1974

Annual Session		$22,191.95
Council		10,042.79
Delegates to A.M.A.		14,414.33
Public Affairs		5,448.99
Woman's Auxiliary		2,545.19
Commissions:		
Commission on Medical Economics, Third Party Medicine and Governmental Relations	$ 59.31	
Commission on Continuing Education & Health Manpower	805.09	
Commission on Medical-Legal Affairs	462.05	
Committee on Legislative Affairs	38.31	
Committee on Planning	24.18	
Committee on Voluntary Health Agencies	14.21	1,403.15
Total		$56,046.40

Exhibit C-2

Statement of Investments December 31, 1974

Description	*Bonds at Par*	*Cost*
Pacific Gas & Electric 4½% due 6/1/90	$5,000.00	$ 5,000.00
Johns-Mansville 400 shares		5,582.34
Central & Southwest Corp. 400 shares		6,345.62
American Home Products Corp. 150 shares		3,006.88
Firestone Tire & Rubber Co. 140 shares		3,771.93
Baker Oil Co. 165 shares		5,940.09
Interco-Common no par 420 shares		12,407.63
J. P. Morgan & Co. 244 shares		5,161.93
International Tele. & Tele. Corp. 100 shares		6,986.25
Bankamerica Corp. 400 shares		13,751.15
Texaco, Inc. 200 shares		6,937.26
International Paper 145 shares		5,563.01
		$80,454.09

Exhibit D-1

Missouri State Medical Association
Dues Receivable and Membership by Societies
December 31, 1974

	MEMBERSHIP				
	Junior	*Active*	*Honor*	*Total*	*Unpaid Dues*
Andrew		3		3	
Audrain		22	1	23	$ 75.00
Barton		3	2	5	
Boone	9	184	5	198	1,407.50
Buchanan		93	14	107	300.00
Butler-Wayne-Ripley		51	1	52	150.00
Callaway		16		16	
Cape Girardeau	2	59	3	64	
Chariton-Macon-Monroe-Randolph		16	3	19	
Clay	1	100	3	104	347.50
Clinton		3	1	4	
Cole	1	60	3	64	225.00
Cooper		7		7	
Dallas-Hickory-Polk-Dade		9	1	10	
Dunklin		18	1	19	
Franklin-Gasconade-Warren		26	1	27	150.00
Grand River		35	4	39	150.00
Greene		218	11	229	
Henry		5	3	8	
Howard		4		4	
Jackson	10	823	142	975	1,097.50
Jasper	1	72	5	78	450.00
Jefferson		20	2	22	75.00
Johnson		14	1	15	
Lafayette-Ray		21		21	
Lewis-Clark-Scotland		1		1	
Marion-Ralls-Shelby		25	1	26	
Mid Missouri		29	1	30	75.00
Miller		2		2	
Mineral Area		32	3	35	
Moniteau		3		3	
Montgomery		1		1	
Morgan		6		6	
North Central		2	2	4	
Northwest Mo.		13		13	300.00
Ozark		36	4	40	150.00
Pemiscot		11		11	
Perry-Ste. Genevieve		10	3	13	
Pettis		28		28	

Pike		8		8	
Platte		5		5	
St. Charles-Lincoln		61	1	62	75.00
St. Louis City	105	1392	136	1633	2,025.00
St. Louis County	10	479	47	536	
Saline		8		8	
Semo		30	4	34	75.00
South Central		19		19	75.00
Webster		2		2	
West Central		32	7	39	
Totals	139	4117	416	4672	$7,202.50 (A)

(A) Delinquent dues of members at December 31, 1974 carried at the request of local Societies.

FINANCIAL STATEMENT FOR THE YEAR 1974

LENNERSTON & COMPANY
Certified Public Accountants
ST. LOUIS, MISSOURI 63144

January 29, 1975

Missouri State Medical Foundation
113 Madison
Jefferson City, Missouri 65101

Gentlemen:

An examination was made of the Balance Sheet of the Missouri State Medical Foundation, a non-profit Missouri corporation, for the year 1974. The Balance Sheet at December 31, 1974 is on the cash basis and the additions and deductions for the year are set forth in Exhibit A.

Recorded receipts for the year were traced in total into the bank account as deposits and paid checks were seen for the disbursements. A direct confirmation was received from the depository in verification of the cash balances on deposit.

A summary of the loans to medical students follows:

Loans Receivable January 1, 1974	$477,672.66
Loans made during the year	79,000.00
Total	$556,672.66
Less Loan Repayments	34,092.83
Loans Receivable December 31, 1974	$522,579.83

Positive confirmations were mailed on 335 individual loans stating their principal loan balances as of September 25, 1974. As of January 14, 1975, 320 confirmations have been returned confirming their principal loan balances at September 25, 1974 of $504,138.73 out of total loans of $522,579.83. Interest income on loans is recorded on a cash basis and the amount received in 1974 was $11,648.47. Accrued interest on outstanding loans at December 31, 1974 amounted to $36,029.40 and is not included in the loan balances in Exhibit A.

The Foundation has set up a reserve for losses on student loans in the amount of .05% monthly on the outstanding loan balances. An addition of $3,091.81 was made for the year 1974 resulting in a reserve balance of $5,846.57 at December 31, 1974.

Interest received on the savings account and the certificates of deposit amounted to $3,962.93 of which $1,838.33 were earned on certificates of deposit in 1973. The certificates of deposit were redeemed on the due dates and the money was deposited to the savings and checking account.

The Missouri State Medical Foundation incurred the following expenses for the year ended December 31, 1974:

State Registration Fee	$ 1.00
Professional Fees	1,445.00
Office Expense	16.45
Printing	76.75
Administrative Service	6,600.00
Addition to Reserve for Losses	3,091.81
Total	$11,231.01

U. S. Treasury Department form 990 and Schedule A will be prepared for the year 1974 and are due for filing by May 15, 1975. The Foundation is not liable for Federal Income Taxes as it is classified as a Tax Exempt Charitable Organizaiton.

We have examined the Balance Sheet of Missouri State Medical Foundation as of December 31, 1974, prepared on the cash basis. The examination was made in accordance with generally accepting auditing standards and include such tests of the accounting records and such other auditing procedures as we considered necessary in the circumstances. Since the Balance Sheet is on the cash basis, no opinion is expressed on the attached statement as accrued interest on loans of $36,029.40 is not shown.

Yours very truly,
Lennerston & Co.
Certified Public Accountants

Missouri State Medical Foundation
Balance Sheet (Cash Basis), December 31, 1974

Assets

Cash		
Checking Account	$ 44,936.24	
Savings Account #05842586	47,086.21	
Total Cash		$ 92,022.4
Loans Receivable from Medical Students	$522,579.83	
Less Reserve for Losses	5,846.57	516,733.2
		$608,755.7

Fund Reserve

Balance January 1, 1974		$561,548.3
Additions for the Year 1974		
Interest on Student Loans	$ 11,648.47	
Interest on Bank Deposits	3,962.93	
Contributions (detailed below)	2,777.00	
Assessment of Members, Active $10.00	40,050.00	58,438.4
		$619,986.7
Less Expenses for the Year 1974		
Administrative Services	$ 6,600.00	
Professional Fees	1,445.00	
Printing, Meeting and Misc. Expense	94.20	
Provision for Losses on Student Loans	3,091.81	11,231.0
		$608,755.7

Contributions

Cole County Medical Auxiliary	$ 367.0
Woman's Auxiliary to MSMA	300.0
Woman's Auxiliary to Jackson County	100.0
Grand River Medical Society	200.0
West Central Missouri Medical Society	250.0
Max S. Franklin, M.D.	100.0
Albert D. Cross, M.D.	100.0
Greene County Medical Auxiliary	100.0
Doyle C. McGraw, M.D.	100.0
Clay County Medical Auxiliary	830.0
Sub Total	$2,447.0
Contributions under $100 each	330.0
Total Contributions	$2,777.0

Attend the
117th MSMA Annual Session—April 17-20, 1975
Chase-Park Plaza Hotel St. Louis

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ANTED—Full-time occupational physician for permanent nployment in Remington Arms Company plant in Indeendence, Missouri. Excellent opportunity. General practice ackground acceptable. Excellent salary and outstanding mpany-paid benefit program. An equal opportunity emloyer. Write or call A. Travostino, Plant Manager, Remingn Arms Company, Inc., Lake City Army Ammunition lant, Independence, Missouri 64050 (816) 796-7101. M/F.

AMILY PRACTITIONER—Board certified. Wants associe now to purchase practice in December, 1975. North St. ouis County, middle class community. Located near two spitals. Six-figure gross with potential for growth. Fiancial details negotiable. Practice also suited for internist. ontact Mr. Leggat, Medserco, Inc., 7733 Forsythe Blvd., layton, Mo. 63105. AC 314-726-0400.

ELP!—Losing my associate to residency. Busy surgical d medical practice in rapidly developing rural-suburban ea, less than 50 minutes from anywhere in St. Louis, 4-ne all the way. Office adjacent to 100-bed general hostal. Need American-educated physician interested in inrnal medicine. Some emergency room coverage and surcal assistance. Terms open, depending on experience. rite to Box 401, Missouri State Medical Association, 113 adison, Jefferson City, Mo. 65101.

IDWEST CLINIC—Seeking INT/CARD/OB-GYN/FP/NT/PED. Fine benefits, attractive surroundings, variety of cations. Write Box 11241, St. Louis, Mo. 63105.

RADIOLOGIST DESIRES POSITION—Preferably part-time in private practice with small hospital, multispecialty or GP group. Reply to Box 403, Missouri State Medical Association, 113 Madison, Jefferson City, Mo. 65101.

LOCUM TENENS WORK—Sought by 52-year-old, semi-retired G.P. Twenty-seven years' solo experience in small Missouri town. Credentials upon request. F. A. Elders, M.D., P.O. Box 10, Cuba, Mo. 65453.

FOR SALE—FO 9000PL Polydirectional Colonoscope, 185 cm. New cables, fibers, main flex. shaft with case. Also with FCB-95 Power light supply, air supply, biopsy forceps, Wappler #9110A (80") polypectomy snare. $4,000. For information, please call Dr. Campbell at 816-333-7565.

BOARD ELIGIBLE—General Surgeon, 36, Flex. Seeks association, group, partnership or solo practice. Willing to do some general practice. Call 314-965-0899 or write Box 402, Missouri State Medical Association, 113 Madison, Jefferson City, Mo. 65101.

SITUATION WANTED—General Practitioner, 18 years experience. Would like to join partnership, group or association. Respond to Box 400, Missouri State Medical Association, 113 Madison, Jefferson City, Mo. 65101.

REFINERY MEDICAL DIRECTOR

Major petrochemical company has opening for REFINERY MEDICAL DIRECTOR in St. Louis area. A challenging new post for a physician strong in clinical, occupational and preventive medicine, with an interest in occupational medical administration. Excellent fringe benefits. Will direct occupational health program for 2,000 employees. 4 nurses in existing department. Salary negotiable.

Previous industrial experience desirable, but not mandatory. Please send resume, with minimum salary requirements, in confidence, to: Box 399, Missouri State Medical Association, 113 Madison, Jefferson City, Mo. 65101.

LEO H. POLLOCK, M.D

Missouri Medicine in Review

FORTY YEARS AGO

The annual dinner meeting of the Boone County Medical Society was held in the Colonial Room of the Tiger Hotel on Dec. 4, 1934 with 21 members present. After a delicious dinner, the meeting was called to order by the President, Dr. A. R. McComas, Sturgeon. The following officers for 1935 were elected by acclamation following nomination from the floor: President, Dr. W. P. Dysart, Columbia; Vice-President, Dr. W. O. Fischer, Columbia; Secretary, Dr. Maurice E. Cooper, Columbia; member of the Board of Censors for 1935-1937, Dr. C. M. Sneed, Columbia; Delegate, Dr. F. G. Nifong, Columbia; Alternate, Dr. R. S. Battersby, Columbia; and member of the auxillary Committee on Public Policy, Dr. D. A. Robnett, Columbia. After the election of officers, Dr. M. D. Overholser of Columbia gave an extremely well-received performance in the art of sleight of hand and magic.

The Cass County Medical Society held its regular quarterly meeting on Dec. 13, 1934 in Harrisonville. President T. W. Adair of Archie presided. The following officers were elected: President, Dr. B. B. Tout, Archie; Secretary-Treasurer, Dr. J. S. Triplett, Harrisonville.

TWENTY-FIVE YEARS AGO

Seventeen members were made fellows and associate fellows of the United States Chapter, International College of Surgeons at the 14th annual meeting in Atlantic City on November 7-11. They are Drs. W. A. Bloom, Fayette; Karl D. Dietrich, Columbia; Winfred L. Post, Joplin; Vincent A. Schneider, St. Charles; Horace Arch Lowe and Walter R. Langston, Springfield; Philip H. Halperin, Mark M. Marks, O. Jack Printz and Joseph A. Nigro, Kansas City; L. C. Boemer, C. H. Shutt William H. Sinkler, Leo J. Hartnett, B. L. Sinner Edgar W. Davis and Rubin Hackmeyer, St. Louis

John Zahorsky, M.D., Steelville, was granted a emeritus fellowship by the American Academy o Pediatrics at a recent meeting of the Academy hel in San Francisco.

Dr. Andy Hall, Sr. of Mount Vernon, Ill., wa named “outstanding general practitioner of th year” by the American Medical Association. He i the father of Dr. Andy Hall, Jr. of St. Louis.

Sherwood Moore, M.D., St. Louis, was electe vice-president of the American Cancer Society a the annual meeting of the organization in Ne York on Oct. 27-30, 1949.

TEN YEARS AGO

Parke, Davis & Company has announced plan for the nationwide distribution of measles vaccine The vaccine was developed by Philips Roxane, Inc of St. Joseph, Mo. and Columbus, Ohio and recentl was approved by the federal government. The vaccine is the live, attenuated type and is indicated fo preventive immunization against naturally occu ring nine-day measles. According to the company the vaccine has produced no serious side effect during the clinical field trials involving approximately 130,000 children, and these trials hav proved the effectiveness of the vaccine with pr dicted lifelong immunity in 94% to 97% of thos vaccinated.

Dr. Carl Cori has been named distinguished se vice professor of biological chemistry at Washington University School of Medicine. One of th world's leading biochemists, Dr. Cori was cited f his outstanding service to the School of Medicin to the University and to medical science in genera He joined the Washington University faculty as professor of pharmacology in 1931 and became pr fessor of biological chemistry and head of the d partment in 1947. Dr. Cori was awarded the Nob Prize in 1947 jointly with his wife, the late D Gerty Cori, for work on the conversion in the bod of glycogen into glucose.

Disruptive anxiety usually meets its match here.

Often effective when reassurance and counseling are insufficient.
Three dosage strengths to meet most therapeutic needs.

Before prescribing, please consult complete roduct information, a summary of which ollows:

Indications: Relief of anxiety and tension ccurring alone or accompanying various isease states.

Contraindications: Patients with known ypersensitivity to the drug.

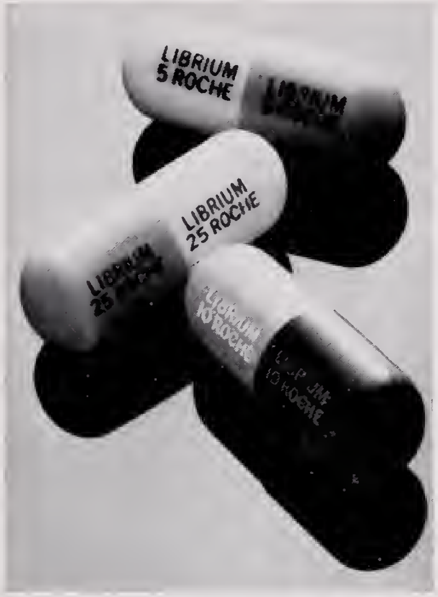
Warnings: Caution patients about possible ombined effects with alcohol and other CNS epressants. As with all CNS-acting drugs, aution patients against hazardous occupaions requiring complete mental alertness .g., operating machinery, driving). Though hysical and psychological dependence have arely been reported on recommended doses, se caution in administering to addiction-rone individuals or those who might increase osage; withdrawal symptoms (including onvulsions), following discontinuation of the rug and similar to those seen with barbituates, have been reported. Use of any drug in regnancy, lactation, or in women of childearing age requires that its potential benefits e weighed against its possible hazards.

Precautions:

ORAL: In the elderly and debilitated and in hildren over six, limit to smallest effective osage (initially 10 mg or less per day) to reclude ataxia or oversedation, increasing radually as needed and tolerated. Not recomnended in children under six.

INJECTABLE: Keep patients under observaon, preferably in bed, up to three hours after nitial injection; forbid ambulatory patients to perate vehicle following injection; do not dminister to patients in shock or comatose tates; use reduced dosage (usually 25 to 50 ng) for the elderly or debilitated and for hildren age twelve or older.

ORAL AND INJECTABLE: Though generally ot recommended, if combination therapy ith other psychotropics seems indicated, arefully consider individual pharmacologic ffects, particularly in use of potentiating ompounds such as MAO inhibitors and henothiazines. Observe usual precautions in resence of impaired renal or hepatic funcon. Paradoxical reactions (e.g., excitement, timulation and acute rage) have been eported in psychiatric patients and hyperctive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.



Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

With the injectable form, isolated instances of hypotension, tachycardia and blurred vision have been reported; also hypotension associated with spinal anesthesia, and pain following I.M. injection.

Usual Daily Dosage: Individualize for maximum beneficial effects. *Oral: Adults:* Mild and moderate anxiety and tension, 5 or 10 mg *t.i.d.* or *q.i.d.*; severe states, 20 or 25 mg *t.i.d.* or *q.i.d. Geriatric patients:* 5 mg *b.i.d.* to *q.i.d.* (See Precautions.)

For Parenteral Administration: Should be individualized according to diagnosis and response. While 300 mg may be given during a 6-hour period, do not exceed this dose in any 24-hour period. To control acute conditions rapidly, the usual initial adult dose is 50 to 100 mg I.M. or I.V. Subsequent treatment, if necessary, may be given orally. (See Precautions.)

Supplied:

Oral: Librium® (chlordiazepoxide HCl) *Capsules*—5 mg, 10 mg, 25 mg—bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 50, available singly and in trays of 10.

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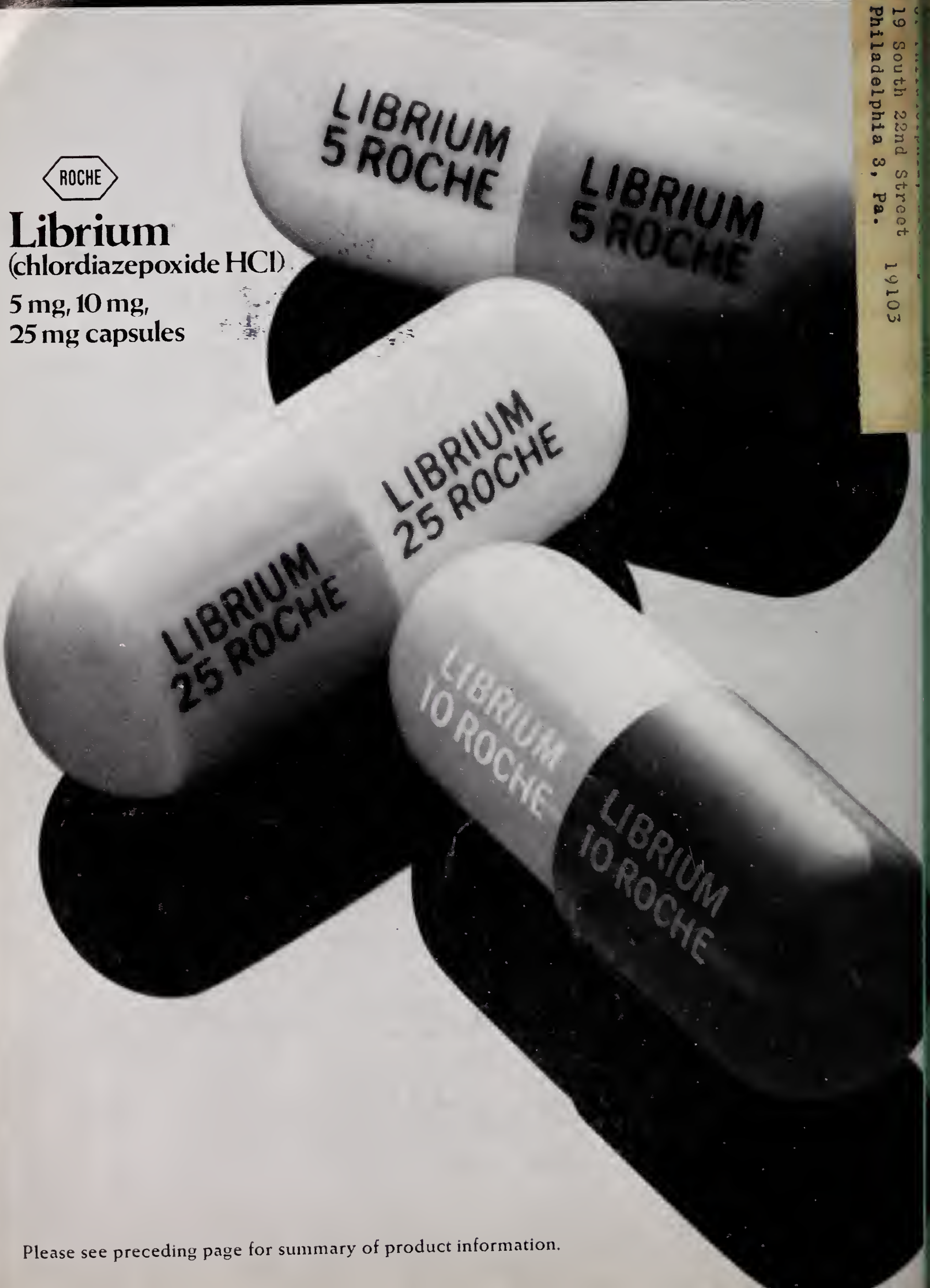
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Missouri Medicine

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University of Missouri-Columbia Medical Center
SPECIAL ISSUE

Both ofte

Predominant psychoneurotic anxiety
Associated depressive symptoms

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in f qu
and/or severity of grand mal seiz es
require increased dosage of stan rd
convulsant medication; abrupt w dr
may be associated with temporar n-
crease in frequency and/or sever o
seizures. Advise against simultar ou
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(convulsions, tremor, abdominal d
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addiction-prone individuals unde ar

espond to one

According to her major
ptoms, she is a psychoneu-
patient with severe
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ngs, part of the problem
sound like depression.
is because her problem,
ugh primarily one of ex-
ve anxiety, is often accom-
ed by depressive symptom-
gy. Valium (diazepam)
rovide relief for both—as
xcessive anxiety is re-
d, the depressive symp-
associated with it are also
relieved.

There are other advan-
in using Valium for the
agement of psychoneu-
anxiety with secondary
essive symptoms: the
otherapeutic effect of
m is pronounced and
l. This means that im-
ement is usually apparent

in the patient within a few days rather than in a week or two, although it may take longer in some patients. In addition, Valium (diazepam) is generally well tolerated; as with most CNS-acting agents, caution patients against hazardous occupations requiring complete mental alertness.

Also, because the psychoneurotic patient's symptoms are often intensified at bedtime, Valium can offer an additional benefit. An *h.s.* dose added to the *b.i.d.* or *t.i.d.* treatment regimen can relieve the excessive anxiety and associated depressive symptoms and thus encourage a more restful night's sleep.

Valium®
(diazepam)
2-mg, 5-mg, 10-mg tablets

in psychoneurotic
anxiety states
with associated
depressive symptoms

llance because of their predisposi-
habituation and dependence. In
ancy, lactation or women of child-
g age, weigh potential benefit
st possible hazard.
utions: If combined with other psy-
pics or anticonvulsants, consider
lly pharmacology of agents em-
l; drugs such as phenothiazines,
tics, barbiturates, MAO inhibitors
her antidepressants may potentiate
ion. Usual precautions indicated in
ts severely depressed, or with latent
ssion, or with suicidal tendencies.

Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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Missouri Medicine

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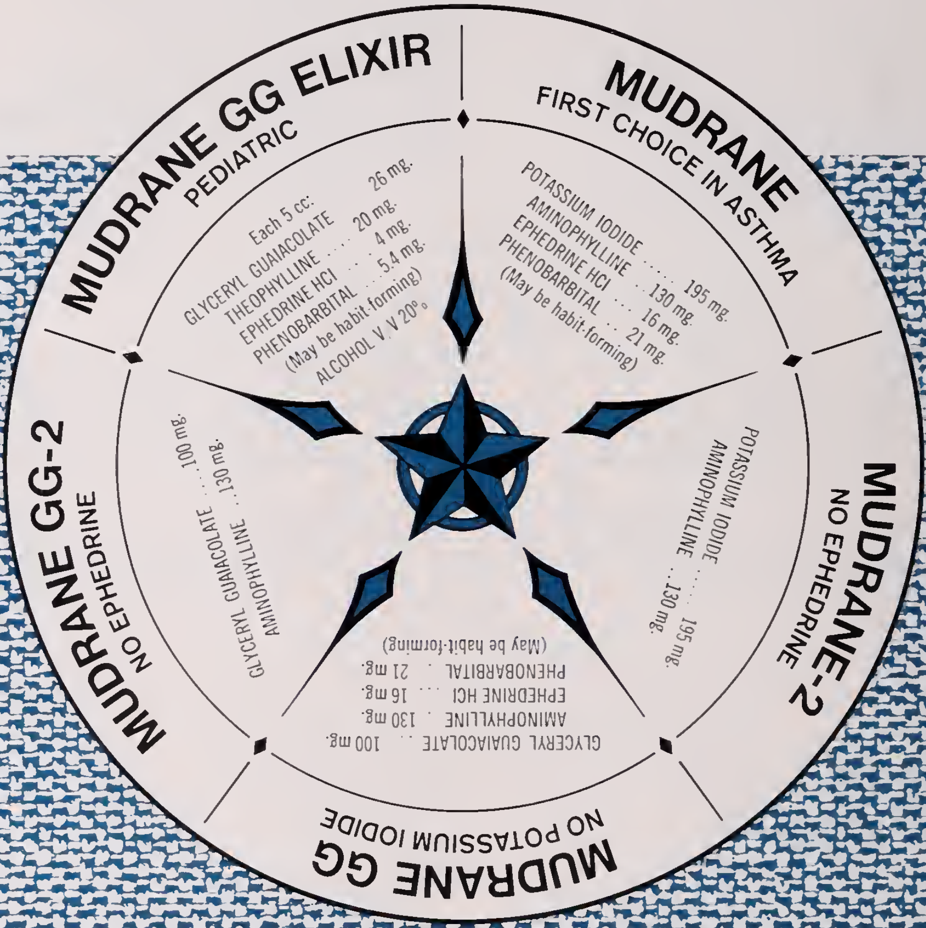
The MUDRANES

Discreet formulations of four well regarded drugs for the relief of bronchial distress—Potassium Iodide, Glyceryl Guaiacolate, Aminophylline, Ephedrine with Phenobarbital (to lessen cardiac stimulation).



MUDRANE
FIRST CHOICE IN ASTHMA
POTASSIUM IODIDE ..... 195 mg.
AMINOPHYLLINE .. 130 mg.
EPHEDRINE HCl ... 16 mg.
PHENOBARBITAL .. 21 mg.
(May be habit-forming)

MUDRANE-2
NO EPHEDRINE
POTASSIUM IODIDE ..... 195 mg.
AMINOPHYLLINE .. 130 mg.

MUDRANE GG
NO POTASSIUM IODIDE
GLYCERYL GUAIACOLATE .. 100 mg.
AMINOPHYLLINE .. 130 mg.
EPHEDRINE HCl ... 16 mg.
PHENOBARBITAL .. 21 mg.
(May be habit-forming)

MUDRANE GG-2
NO EPHEDRINE
GLYCERYL GUAIACOLATE .. 100 mg.
AMINOPHYLLINE .. 130 mg.

MUDRANE GG ELIXIR
PEDIATRIC
Each 5 cc:
GLYCERYL GUAIACOLATE .. 26 mg.
THEOPHYLLINE .... 20 mg.
EPHEDRINE HCl .. 4 mg.
PHENOBARBITAL .. 5.4 mg.
(May be habit-forming)
ALCOHOL V V 20°

INDICATIONS: For the prompt symptomatic relief of bronchial asthma, emphysema and bronchiectasis. The Mudranes dilate the bronchi and liquefy mucus plugs. DOSAGE: Tablet; One tablet with a full glass of water 3 or 4 times daily as required. Divide tablet for child's dose. Elixir; Children, 1 cc for each 10 lbs. of body weight. May be repeated 3 or 4 times a day. Adult, one tablespoonful 4 times daily. All doses should be followed with a glass of water.

CONTRAINDICATIONS: Aminophylline/Theophylline is contraindicated in the presence of severe cardiac arrhythmias and patients with massive myocardial damage. Ephedrine, in presence of severe heart disease, extreme hypertension, and in hyperthyroidism. Phenobarbital, in porphyria and in patients with known phenobarbital sensitivity. Potassium Iodide, in pregnancy (to protect the fetus against possible iodine-induced depression of thyroid activity), in tuberculosis (produces gumma dissolution), and in acne; also in the presence of known iodide sensitivity. PRECAUTIONS: Aminophylline/Theophylline should be avoided in patients with massive myocardial damage and/or severe cardiac arrhythmias. In children, overdose may cause vomiting, cardiac arrhythmias, and severe agitation. Ephedrine should be used with caution in the presence of severe cardiac disease, particularly arrhythmias and angina pectoris; avoid in hyperthyroidism and severe hypertension. Phenobarbital may be habit-forming. Avoid overdosage. Potassium Iodide: Discontinue in the presence of skin rash, swelling of the eyelids and severe frontal headache. Long use may cause goiter. ADVERSE REACTIONS: Aminophylline/Theophylline may cause nausea, cardiac arrhythmias, and aggravate severe myocardial disease. It may cause headaches and tachycardia. Vomiting and dizziness are not uncommon. Ephedrine: In patients hypersensitive to CNS stimulation, ephedrine may cause nervousness, tachycardia, extrasystole and ventricular arrhythmias. May cause urinary retention, especially in the presence of partial prostatic obstruction. Psychoneurosis may be aggravated. Pre-existing anginal pain will be aggravated. Phenobarbital may produce severe skin rash. Avoid overdosage. May be habit-forming. Potassium Iodide may cause nausea. Over very long period of use, iodides cause goiter. Discontinue if patient develops skin rash, eye irritation, eyelid swelling, or severe frontal headache.

HOW SUPPLIED: Mudrane and Mudrane GG available in bottles of 100 and 1000 tablets; Mudrane-2 and Mudrane GG-2 in 100s; Elixir in pints and half-gallons.

Federal law prohibits dispensing without prescription.

WILLIAM P. POYTHRESS & COMPANY, INC., RICHMOND, VIRGINIA 23261

The post-T & A patient:

another type for TYLENOL® acetaminophen products

When the post-T & A patient requires an analgesic, a new problem arises. Hemorrhagic tendencies following the use of aspirin after tonsillectomies have been reported.[1,2] In a patient who "...has recently undergone a surgical procedure or has another underlying hemostatic defect, aspirin ingestion may cause significant bleeding.... Aspirin is absolutely contraindicated in such situations. Acetaminophen...could replace aspirin in these instances."[3]

The post-T & A patient is only one of several 'types for TYLENOL' antipyretic-analgesic products—that is, patients who should avoid aspirin. Considering *all* of them, wouldn't it provide added safety (as well as added convenience) to recommend TYLENOL products routinely for simple analgesia?

References: 1. Reuter, S.H., and Montgomery, W.W.: Arch. Otolaryng. *80*:214-217 (Aug.) 1964. **2.** Osol, A., et al., ed.: The United States Dispensatory and Physicians' Pharmacology, ed. 26, Philadelphia, J.B. Lippincott Co., 1967, p. 171. **3.** Schwartz, A.D., and Pearson, H.A.: J. Pediat. *78*:558-560 (March) 1971.

Precautions and Adverse Reactions: If a rare sensitivity reaction occurs, the drug should be stopped. Acetaminophen has rarely been found to produce any side effects.

Elixir, 120 mg./5cc. (alcohol 7%).
Drops, 60 mg./0.6cc. (alcohol 7%).
Chewable Tablets, 120 mg.

Safer than aspirin, yet just as effective for relief of pain and fever

TYLENOL®
acetaminophen products

McNEIL McNeil Laboratories, Inc., Fort Washington, Pa. 19034

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in Brief

A summary of AMA, medical & health news

American Medical Association / 535 North Dearborn Street / Chicago, Illinois 60610 / Phone (312) 527-1500 / TWX 910-221-0300

The AMA sued HEW to seek both a preliminary and a permanent injunction against implementation of new utilization review regulations on the grounds that they violate the constitutional rights of both patients and physicians, exceed the authority granted to the HEW secretary by the Social Security Act and violate the section of the act that forbids "any federal officer or employee to exercise any supervision or control over the practice of medicine or the manner in which medical services are provided." The regulations require that every decision by a physician to hospitalize a Medicare or Medicaid patient be evaluated by the hospital's UR committee within one working day. Non-physicians may serve on these committees. Joining in the AMA suit were ten patients and five Illinois physicians. It was the first time the AMA ever filed suit against HEW.

The Comprehensive Health Care Insurance Act of 1975, AMA's new national health insurance bill, was approved by the Board of Trustees for introduction in Congress. The bill, which includes principles endorsed by the House of Delegates, would assure availability of full health care coverage to all. Features of the new bill include mandated employer coverage, income tax credits for the self-employed and nonemployed who buy health insurance, subsidies for supplemental Medicare coverage for the nonemployed elderly, and through an amendment to the unemployment compensation program, continuation of an employees' health insurance when he is terminated.

As part of the action program approved by the AMA Board of Trustees in January concerning the medical liability insurance problem, the Office of General Counsel distributed a packet of material containing model state legislation and copies of bills already introduced in state legislatures to executive directors of state, metropolitan county and specialty medical societies.

Of the 248 candidates AMPAC supported for the House of Representatives in the 1974 election, 183 were successful for a winning percentage of 73.8. AMPAC supported 22 Senatorial candidates and 14 (63.6%) won election. During the two-year campaign—1973 and 1974—AMPAC contributed $1,104,305.19 to candidates. In 1974, AMPAC filed contribution reports with the federal government 198 times.

Eight bills have been prepared for introduction in the 94th Congress by the AMA. The proposals deal with the establishment of an Office of Rural Health in HEW; the PSRO law; antitrust laws as they apply to blood banking; drug container labels dispensed to patients; the Internal Revenue Code as it applies to medical and drug expense and automobile expense deductions; the Social Security Act as it applies to malpractice claimants who receive, as part of recovered damages, costs of health care services which may be paid by Social Security; and the law which authorizes special bonus pay for members of the uniformed services.

Congress will handle health proposals differently than it has in the past. The House Ways and Means Committee has been reorganized into subcommittees, some of its jurisdiction has been passed to the House Commerce Committee and the Democratic Caucus has assumed new power over the timing of legislation in the 94th Congress. Major emphasis in the Ways and Means' Subcommittee on Health will be placed on written statements from the general public which must contain an opening summary; a list of persons or organizations represented, including the total membership of an organization; and a topical outline of comments made in the full statement.

More than 30 national specialty societies helped the AMA develop a model screening criteria format for PSROs. The model format and criteria will be sent to state and county medical societies, specialty societies, conditional and planning PSROs and hospitals in April. The criteria are designed to serve as reference points for physicians in developing criteria for local PSROs and to assist in review processes of hospital admissions certification, continued stay review and care evaluation studies. Funding for the project comes from HEW.

medical melange

Notes of interest from Here .... and There

Dr. Donald H. Giesler of Osceola is the recipient of a special ward from Provost Joseph M. White of the University of Missouri-Columbia School of Medicine for his work in establishing a Development Program for the School of Medicine. A member of the Class of 1945, he also was recognized in 1972 for distinguished achievements by the Alumni Association of the University of Missouri-Columbia. Dr. Giesler served as a preceptor for the School of Medicine, is a member of the V Club and a Distinguished Fellow of the Jefferson Club at the University.

Dr. Joseph S. Cope was honored on March 10 at an awards banquet of the Lexington Chamber of Commerce and Lexington Industrial Development Corporation. **Mr. Warren Sherman, Jr.,** master of ceremonies for the banquet, presented Dr. Cope with an inscribed copy of a Missouri Senate resolution recognizng him for his "unselfish contributions to the people of his community." The resolution was presented to the Senate by Sen. Ike Skelton of Lexington. One of he speakers at the dinner was MSMA **President James C. Cope** of Columbia, Dr. Joseph Cope's brother.

Dr. I. W. Kimball has been elected president of the Kansas City Academy of Family Physicians. Other new officers are **Dr. Donald A. Potts,** president-elect; **Dr. Mary Cortner,** treasurer; **Dr. Joseph Johnson,** secretary. **Dr. Walter J. Stelmach** was named "Family Physician of the Year" by the Academy.

Dr. C. W. Chastain, Farmington, has been chosen to chair the Task Force on Inpatient Services of the Governor's Advisory Council on Comprehensive Health Planning. The Task Force will work to develop plans for improved hospital and nursing home services in Missouri. Dr. Chastain previously served on Governor's Task Forces on Accessibility to Health Care and on Criteria for Certificate of Need Regulations.

Dr. William Costen has been elected president of the Medical Staff Association of St. Luke's Hospitals in St. Louis. He succeeds **Dr. Neville Grant. Dr. Theodore Meiners** was elected treasurer of the association and **Drs. Jorge M. Alegre, James M. Stokes** and **J. Leslie Walker** were elected as representatives to the Association's administrative committee. **Dr. William F. McGinnis** has been appointed chief of obstetrics-gynecology for St. Luke's Hospitals to succeed **Dr. Carol F. Williams,** who will devote full time to private practice and also continue to serve on the hospital staff.

Dr. Kenneth Siu has been elected president of the Jefferson City Family YMCA board of directors.—**Dr. Harold Jones,** Springfield, was a guest speaker at the ourth district meeting of the Missouri Nurses' Association in Springfield.—**Dr. James P. McGonigle** recently spoke on "diabetic retinopathy" at a meeting of the oplin Diabetes Association.

Must vasodilators and therapy for other diseases come into conflict?

not if the vasodilator is

VASODILAN®

(ISOXSUPRINE HCl)

the compatible vasodilator... no treatment conflicts reported

The cerebral or peripheral vascular disease patient often has coexisting disease[1] which calls for another drug along with his vasodilator. It may be a hypoglycemic, miotic, antihypertensive, diuretic, anticoagulant, corticosteroid, or coronary vasodilator.

Vasodilan is not incompatible with any of these drugs—no treatment conflict has been reported. And, unlike other vasodilators, Vasodilan has not been reported to affect carbohydrate metabolism, liver function, or intraocular pressure—or to complicate treatment of diabetes, hypertension, peptic ulcer, glaucoma, or liver disease.

In fact, there are no known contraindications to the use of Vasodilan in recommended oral doses, other than that it should not be given in the presence of frank arterial bleeding or immediately postpartum.

Indications: Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows:

Possibly Effective:

1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.
3. Threatened abortion.

Final classification of the less-than-effective indications requires further investigation.

Composition: Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg.

Dosage and Administration: 10 to 20 mg. three or four times daily.

Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

Adverse Reactions: On rare occasions, oral administration of the drug has been associated in time with the occurrence of severe rash. When rash appears, the drug should be discontinued. Occasional overdosage effects such as transient palpitation or dizziness are usually controlled by reducing the dose.

Supplied: Tablets, 10 mg.—bottles of 100, 1000, 5000 and Unit Dose; 20 mg.—bottles of 100, 500 and Unit Dose.

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MeadJohnson LABORATORIES

1. Gertler, M. M., et al.: Geriatrics *25*:134-148 (May) 1970.

MSMA

NEWS
ROUND - UP

APRIL, 1975

Contracts signed

MSMA sets up malpractice firm

Responding to a growing crisis in Missouri and the dictates of the House of Delegates, the Missouri State Medical Association created an Association-sponsored professional liability insurance company effective March 24, 1975.

The company, MSMI, Inc., resulted from nearly a year of investigation, studies, reports and discussions between the MSMA, insurance brokers and insurance carriers. The action was initiated in early 1974 following the House of Delegate's instructions to consider forming a professional liability company.

The MSMA owns 100% of MSMI shares. Officers of MSMI are Dr. Irving H. Clark, Kansas City, President; Dr. Howard J. McAlhany, Springfield, Vice-President; and Royal O. Cooper, Jefferson City, Secretary-Treasurer. The Board of Directors is composed of the three officers and Mr. James L. Hamilton and Mr. Timothy S. Danis, both of the Rollins Burdick Hunter Company in St. Louis.

MSMI has signed an exclusive contract designating Rollins Burdick Hunter Company as the agents-of-record. The underwriting manager and carrier represent total assets in excess of $2 billion and show a total surplus in excess of $400 million.

The program is underwritten and funded by a company which specializes in professional liability insurance and currently underwrites programs for eight state Bar Associations plus architects and engineers.

The policy will have a $300,000 limit with a $5 million "umbrella" policy available. It is a modified "occurance-type" policy which incorporates the better features of "occurance" and "claims-made" coverage.

In determining rates, six classes of physicians have been identified and the state has been separated into two areas, metropolitan and out-state. Rates in the out-state area will be somewhat lower than rates in St. Louis, St. Louis County, Jackson County and Clay County.

For purpose of comparison, some examples of the basic annual premium for a $100,000 policy are:

Class I — Internist in St. Louis; $408.
Class II — Family Physician (minor surgery, assisting in major surgery on own patients) in Kansas City; $696.
Class III — Urologist or Ophthalmologist in Hannibal; $1,270.
Class IV — General Surgeon in Poplar Bluff; $2,680.
Class V — OB-GYN or Plastic Surgeon in Columbia; $3,570.
own patients) in Kansas City; $696.
Class VI — Anesthesiologist or Orthopedic Surgeon in Springfield; $4,440.

As stated before, a total of $300,000 basic coverage is available along with the added "umbrella" policy. Rates for the higher coverage are, of course, somewhat higher.

Full details on MSMI will be made available to members at the 117th Annual Session of the Missouri State Medical Association, April 17-20, 1975, at the Chase-Park Plaza Hotel in St. Louis.

MSMA members whose professional liability insurance is subject to renewal within the next 30 days or members who have experienced problems in renewing policies, should contact the Rollins Burdick Hunter Company in St. Louis immediately. The telephone number of the firm is (314) 241-8010.

'Unified membership' on Annual Session agend

"Unified membership" in the AMA will be one of the first and most important items taken up by the House of Delegates during the 117th Annual Session of the Missouri State Medical Association, April 17-20, 1975, at the Chase-Park Plaza Hotel in St. Louis.

"Unified membership" means that when a physician joins the MSMA, he will be required to also join the AMA. Currently, MSMA members have the option of joining AMA.

A list of the Resolutions which have been mailed to Delegates follows:

#1 — Deletion of Legitimacy item from Birth Certificates.

#2 — Refusal to submit patient data to government agencies.

#3 — Establishes MSMA Professional Liability Committee.

#4 — Sets up Committee to organize meetings of component medical societies.

#5 — PSRO — Seeks more local control.

#6 — Opposes proposed Hospital Discharge Data Program.

#7 — Courtesy Resolution — Gov. Christopher Bond.

#8 — Courtesy Resolution — Dr. Herbert R. Domke.

#9 — Professional Liability — Change state laws.

#10 — Patients eligibility to receive Social Security benefits.

#11 — Policies of Veteran Administration hospitals.

#12 — Apply PSRO to government hospitals.

#13 — Professional Liability — Workman's Compensation Law.

#14 — Professional Liability — Contingent fee system.

#15 — Development of individual practice association as alternative to HMO's.

#16 — Invite medical students to MSMA Annual Session.

#17 — PSRO — Seeks repeal.

#18 — Professional liability — No fault insurance.

#19 — Tract V Program of AMA.

#20 — Fluoridation of public water supplies.

#21 — PSRO — Seeks progress report.

#22 — Emergency medical services.

#23 — Licensing power of State Board of Healing Arts.

#24 — Advertising: Physicians and HMO's.

#25 — Community medical directories.

#26 — Third party payers.

#27 — Patient education.

#28 — Physician's assistants.

#29 — Foreign medical graduates.

#30 — Uniform insurance claim form.

#31 — Evaluation of competency.

#32 — Blue Cross reimbursement to surgicenters.

#33 — Federal controls on medical schools.

#34 — Interest charged on unpaid accounts.

Doctor reverses role in malpractice case

A Springfield physician has won a $21,000 default judgement against a Hickory County couple he accused of falsely suing him for malpractice, according to the Springfield *Leader-Press*.

The newspaper reported that Dr. William C. Francis, an orthopedic surgeon, received the judgement in Circuit Judge James H. Keet's court against a Hermitage couple.

The couple's suit, which asks for a total of $115,000, is still pending and the record shows that various motions are being filed, the newspaper stated.

Dr. Francis asked for a total of $65,000 in his original suit. The judgement was for $5,000 actual damages and $15,000 punitive damages in one count and for $1,000 actual damages on a second count.

Dr. Francis alleged in his suit that the defendants brought their suit, filed Dec. 10, with the ulterior motive and purpose of damaging his professional reputation and of causing the doctor to pay the couple in order to preserve his reputation, reported the newspaper.

The defendants' allegations were false, stated Dr. Francis.

The couple's suit, also filed against Cox Medical Center, alleged that the husband was treated at the hospital in December, 1972, after fracturing his right leg. The suit maintained that the husband sustained burns to his leg and foot from the cast and that the hospital staff failed "to exercise that degree of care which a hospital owes to a patient to offer them the facilities necessary to the plaintiff's treatment," the newspaper reported.

Judge Keet's entry showed that the couple was duly summoned, but failed to appear and that the judgement was entered several days later, stated the newspaper.

AMA Board backs St. Louis

The Board of Directors of the AMA will recommend to the AMA House of Delegates that the organization's 1978 Annual Convention be held in St. Louis.

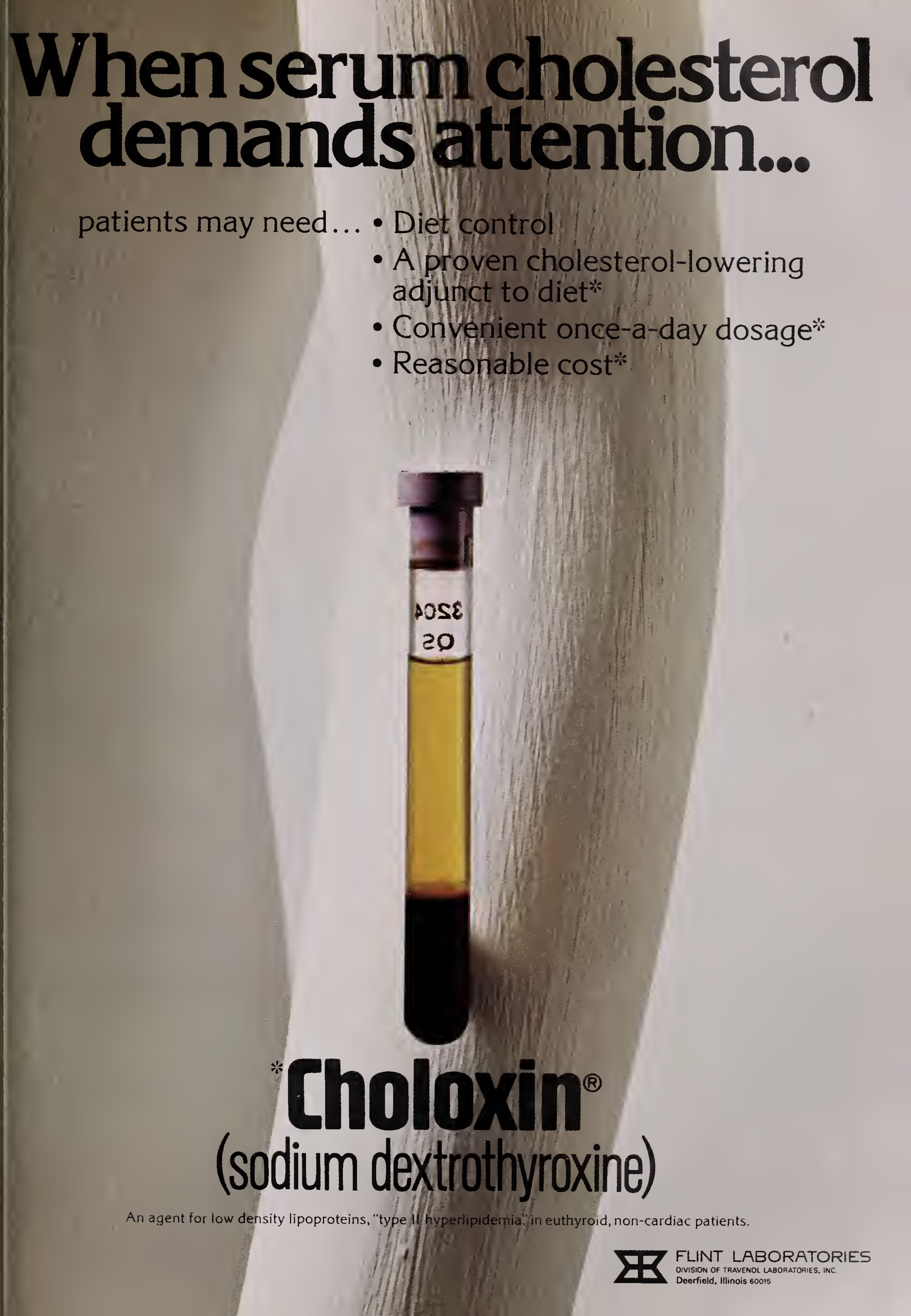
A delegation from St. Louis presented a convincing proposal before the AMA Board during the Clinical Session in Portland.

The Board's recommendation will be presented to the AMA House of Delegates for a final decision at the 1975 Annual Convention in Atlantic City.

MSMA medical education approved

The Missouri State Medical Association has been approved by the American Medical Association to conduct a voluntary program within Missouri for community hospitals and other institutions and organizations providing continuing medical education for MSMA members.

The primary objective of this accreditation program is to identify and document programs of continuing medical education in Missouri that satisfy THE ESSENTIALS OF APPROVED PROGRAMS IN CONTINUING MEDICAL EDUCATION as defined by the AMA.



When serum cholesterol demands attention...

patients may need...
- Diet control
- A proven cholesterol-lowering adjunct to diet*
- Convenient once-a-day dosage*
- Reasonable cost*

***Choloxin®**

(sodium dextrothyroxine)

An agent for low density lipoproteins, "type II hyperlipidemia," in euthyroid, non-cardiac patients.

FLINT LABORATORIES
DIVISION OF TRAVENOL LABORATORIES, INC.
Deerfield, Illinois 60015

Choloxin® (sodium dextrothyroxine)

The Lipid-Lowering Agent with Once-A-Day Dosage

Four strengths . . . 1, 2, 4, and 6 mg. . . . are available making the scored tablet regimen a flexible dosage system. And, for most patients, CHOLOXIN tablets offer once-a-day dosage.

> **AN IMPORTANT NOTE:**
> It has not been established whether the drug-induced lowering of serum cholesterol or lipid levels has a detrimental, beneficial, or no effect on the morbidity or mortality due to atherosclerosis or coronary heart disease. Several years will be required before current investigations will yield an answer to this question.

CHOLOXIN® (sodium dextrothyroxine) Single-Tablet-A-Day Dosage Schedules

See prescribing information in package insert reproduced below.

	Starting Dosage	Increased Monthly by	Usual Maintenance	Maximal Recommended
Adult Hypercholesterolemic	1.0-2.0 mg.	1.0-2.0 mg.	4.0-8.0 mg.	4.0-8.0 mg.
Pediatric Hypercholesterolemic	0.05 mg./kg. body weight	0.05 mg./kg.	0.1 mg./kg. body weight	4.0 mg.
Hypothyroid Cardiac	0.5-1.0 mg.	1.0 mg.	4.0 mg.	4.0 mg.

Choloxin®
(sodium dextrothyroxine)

Description
CHOLOXIN (sodium dextrothyroxine) is the sodium salt of the dextrorotatory isomer of thyroxine. It is chemically described as D-3,5,3′,5′-tetraiodothyronine sodium salt.

Actions
The predominant effect of CHOLOXIN (sodium dextrothyroxine) is the reduction of serum cholesterol levels in hyperlipidemic patients. Beta lipoprotein and triglyceride fractions may also be reduced from previously elevated levels.

Most of the available evidence indicates that CHOLOXIN stimulates the liver to increase catabolism and excretion of cholesterol and its degradation products via the biliary route into the feces. Cholesterol synthesis is not inhibited and abnormal metabolic endproducts do not accumulate in the blood.

Indications
This is not an innocuous drug. Strict attention should be paid to the indications and contraindications.

CHOLOXIN (sodium dextrothyroxine) is an antilipidemic agent used as an adjunct to diet and other measures for the reduction of elevated serum cholesterol (low density lipoproteins) in euthyroid patients with no known evidence of organic heart disease.

The drug is also indicated in the treatment of hypothyroidism in patients with cardiac disease who cannot tolerate other types of thyroid medication.

Before prescribing, note the following: Results from a randomized clinical study have indicated a possible adverse effect when CHOLOXIN is administered to a patient receiving a digitalis preparation. There may be an additive effect. This additive effect may possibly stimulate the myocardium excessively in patients with significant myocardial impairment. CHOLOXIN dosage should not exceed 4 mg per day when the patient is receiving a digitalis preparation concomitantly. Careful monitoring of the total effect of both drugs is important.

It has not been established whether the drug-induced lowering of serum cholesterol or lipid levels has a detrimental, beneficial, or no effect on the morbidity or mortality due to atherosclerosis or coronary heart disease. Several years will be required before current investigations will yield an answer to this question.

Contraindications
The administration of CHOLOXIN (sodium dextrothyroxine) to euthyroid patients with one or more of the following conditions is contraindicated:

1. Known organic heart disease, including angina pectoris; history of myocardial infarction; cardiac arrhythmia or tachycardia, either active or in patients with demonstrated propensity for arrhythmias; rheumatic heart disease; history of congestive heart failure; and decompensated or borderline compensated cardiac status.
2. Hypertensive states (other than mild, labile systolic hypertension).
3. Advanced liver or kidney disease.
4. Pregnancy.
5. Nursing mothers.
6. History of iodism.

Warnings
CHOLOXIN (sodium dextrothyroxine) may potentiate the effects of anticoagulants on prothrombin time. Reductions of anticoagulant dosage by as much as 30% have been required in some patients. Consequently, the dosage of anticoagulants should be reduced by one-third upon initiation of CHOLOXIN therapy and the dosage subsequently readjusted on the basis of prothrombin time. The prothrombin time of patients receiving anticoagulant therapy concomitantly with CHOLOXIN therapy should be observed as frequently as necessary, but at least weekly, during the first few weeks of treatment.

In the surgical patient, it is wise to consider withdrawal of the drug two weeks prior to surgery if the use of anticoagulants during surgery is contemplated.

When CHOLOXIN is used as thyroid replacement therapy in hypothyroid patients with concomitant coronary artery disease (especially those with a history of angina pectoris or myocardial infarction) or other cardiac disease, treatment should be initiated with care. Special consideration of the dosage schedule of CHOLOXIN is required. This drug may increase the oxygen requirements of the myocardium, especially at high dosage levels. Treated subjects with coronary artery disease must be seen at frequent intervals. If aggravation of angina or increased myocardial ischemia, cardiac failure, or clinically significant arrhythmia develops during the treatment of hypothyroid patients, the dosage should be reduced or the drug discontinued.

Special consideration must be given to the dosage of other thyroid medications used concomitantly with CHOLOXIN. As with all thyroactive drugs, hypothyroid patients are more sensitive to a given dose of CHOLOXIN than euthyroid patients.

Epinephrine injection in patients with coronary artery disease may precipitate an episode of coronary insufficiency. This condition may be enhanced in patients receiving thyroid analogues. These phenomena should be kept in mind when catecholamine injections are required in sodium dextrothyroxine-treated patients with coronary artery disease.

Since the possibility of precipitating cardiac arrhythmias during surgery may be greater in patients treated with thyroid hormones, it may be wise to discontinue CHOLOXIN in euthyroid patients at least two weeks prior to an elective operation. During emergency surgery in euthyroid patients, and in surgery in hypothyroid patients in whom it may be advisable to withdraw therapy, the patients should be carefully observed.

There are reports that sodium dextrothyroxine in diabetic patients is capable of increasing blood sugar levels with a resultant increase in requirements of insulin or oral hypoglycemic agents. Special attention should be paid to parameters necessary for good control of the diabetic state in dextrothyroxine-treated subjects and to dosage requirements of insulin or other antidiabetic drugs. If sodium dextrothyroxine is later withdrawn from patients who had required an increase of insulin (or oral hypoglycemic agents) dosage during its administration, the dosage of antidiabetic drugs should be reduced and adjusted to maintain good control of the diabetic state.

When either or both impaired liver or kidney function are present, the advantages of CHOLOXIN therapy must be weighed against the possibility of deleterious results.

Usage in Women of Childbearing Age
Women of childbearing age with familial hypercholesterolemia or hyperlipemia should not be deprived of the use of this drug; it can be given to those patients exercising strict birth control procedures. Since pregnancy may occur despite the use of birth control procedures, administration of CHOLOXIN (sodium dextrothyroxine) to women of this age group should be undertaken only after weighing the possible risk to the fetus against the possible benefits to the mother. Teratogenic studies in two animal species have resulted in no abnormalities in the offspring.

Precautions
It is expected that patients on dextrothyroxine therapy will show greatly increased serum protein-bound-iodine levels. These increased serum PBI values are evidence of absorption and transport of the drug, and should NOT be interpreted as evidence of hypermetabolism; similarly, they may not be used for titrating the effective dose of CHOLOXIN (sodium dextrothyroxine). PBI values in the range of 10 to 25 mcg% in treated patients are common.

If signs or symptoms of iodism develop during CHOLOXIN therapy, the drug should be discontinued.

A few children with familial hypercholesterolemia have been treated with CHOLOXIN for periods of one year or longer with no adverse effects on growth. However, it is recommended that the drug be continued in patients in this age group only if a significant serum cholesterol-lowering effect is observed.

Adverse Reactions
The side effects attributed to dextrothyroxine therapy are, for the most part, due to increased metabolism, and may be minimized by following the recommended dosage schedule. Adverse effects are least commonly seen in euthyroid patients with no signs or symptoms of organic heart disease; the incidence of adverse effects is increased in hypothyroid patients, and is highest in those patients with organic heart disease superimposed on the hypothyroid state.

In the absence of known organic heart disease, some cardiac changes may be precipitated during sodium dextrothyroxine therapy. In addition to angina pectoris, arrhythmia consisting of extrasystoles, ectopic beats, or supraventricular tachycardia, ECG evidence of ischemic myocardial changes and increase in heart size have been observed. Myocardial infarctions, both fatal and non-fatal, have occurred, but these are not unexpected in untreated patients in the age groups studied. It is not known whether any of these infarcts were drug related.

Changes in clinical status that may be related to the metabolic action of the drug include the development of insomnia, nervousness, palpitations, tremors, loss of weight, lid lag, sweating, flushing, hyperthermia, hair loss, diuresis, and menstrual irregularities. Gastrointestinal complaints during therapy have included dyspepsia, nausea and vomiting, constipation, diarrhea, and decrease in appetite.

Other side effects reported to be associated with CHOLOXIN (sodium dextrothyroxine) therapy include the development of headache, changes in libido (increase or decrease), hoarseness, tinnitus, dizziness, peripheral edema, malaise, tiredness, visual disturbances, psychic changes, paresthesia, muscle pain, and various bizarre subjective complaints. Skin rashes, including a few which appeared to be due to iodism, and itching have been attributed to dextrothyroxine by some investigators. Gallstones have been discovered in occasional dextrothyroxine-treated patients and cholestatic jaundice has occurred in one patient, although its relationship to CHOLOXIN therapy was not established.

In several instances, the previously existing conditions of the patient appeared to continue or progress during the administration of CHOLOXIN; a worsening of peripheral vascular disease, sensorium, exophthalmos, and retinopathy have been reported.

CHOLOXIN potentiates the effects of anticoagulants, such as warfarin or Dicumarol, on prothrombin time, thus indicating a decrease in the dosage requirements of the anticoagulants. On the other hand, dosage requirements of antidiabetic drugs have been reported to be increased during dextrothyroxine therapy (see WARNINGS section).

Dosage and Administration
For **adult** euthyroid hypercholesterolemic patients, the recommended maintenance dose of CHOLOXIN (sodium dextrothyroxine) is 4 to 8 mg per day. The initial daily dose should be 1 to 2 mg to be increased in 1 to 2 mg increments at intervals of not less than one month to a maximum level of 4 to 8 mg daily, if that dosage level is indicated to effect the desired lowering of serum cholesterol.

When used as partial or complete substitution therapy for levothyroxine in hypothyroid patients with cardiac disease who cannot tolerate other types of thyroid medication, the initial daily dose should be 1 mg to be increased in 1 mg increments at intervals of not less than one month to a maximum level of 4 to 8 mg daily, preferably the lower dosage. The maximum in patients receiving digitalis therapy is 4 mg.

For **pediatric** hypercholesterolemic patients, the recommended maintenance dose of CHOLOXIN is approximately 0.1 mg per kilogram. The initial daily dosage should be approximately 0.05 mg per kilogram to be increased in up to 0.05 mg per kilogram increments a monthly intervals. The recommended maximal dose is 4 mg daily, if tha dosage is indicated to effect the desired lowering of serum cholesterol.

If new signs or symptoms of cardiac disease develop during the treatmen period, the drug should be withdrawn

How Supplied
CHOLOXIN (sodium dextrothyroxine) is supplied in prescription packages o scored 1, 2, 4, and 6 mg tablets.

FLINT LABORATORIES
DIVISION OF TRAVENOL LABORATORIES INC
Deerfield, Illinois 60015

Medical Grand Rounds

FROM THE VETERANS ADMINISTRATION HOSPITAL
and UNIVERSITY OF MISSOURI-COLUMBIA MEDICAL CENTER

Treatment of End Stage Kidney Disease

Speakers:

Charles E. Mengel, M.D., Professor and Chairman, Department of Medicine, University of Missouri School of Medicine.

Karl D. Nolph, M.D., Associate Professor of Medicine and Director, Division of Nephrology, University of Missouri Medical Center and Veterans Administration Hospital and Chief of Medical Services, Veterans Administration Hospital.

Joseph Montie, M.D., Assistant Professor of Surgery, Urology Division, University of Missouri Medical Center and Veterans Administration Hospital.

Date: **Sept. 26, 1974.**

Dr. Mengel, Chairman, Department of Medi-
ine: In light of the development of our own pro-
rams and the national impact on the chronic renal
isease problem, we will discuss today the success
nd failures of chronic renal failure with hemo-
ialysis and, also, the success and failures of renal
ansplantation at the University of Missouri Med-
al Center. Dr. Karl D. Nolph will begin the dis-
ussion.

Dr. Nolph: What we would like to do today is
take you through many of the steps involved in
roviding care for patients with chronic renal fail-
re. There are many steps and they are complex.
lmost all physicians in all fields see patients with
hronic renal failure. Chronic renal failure is one
f the first health-disaster problems dealt with by
e Congress of the United States. The new laws
this area will influence the activities of everyone
this room. Dialysis and transplantation now can
e made available to the large numbers of patients
ith chronic renal failure.

My first purpose will be to identify the sources
the problem and to try to quantitate it for you.
econdly, I will discuss one of the first approaches
therapy—chronic hemodialysis. We will then
ear from Dr. Joseph Montie who will tell you
ow kidneys are made available for transplanta-
on. After he takes you through the steps of iden-
fying and obtaining such organs, we will come
ack to the patients waiting on dialysis and take
u through the steps of transplantation. We then
ill try to show you statistics which compare the
sults of the two modes of therapy.

One source that we can examine is death certifi-
te information analyzed year by year. There usu-
lly are 25 to 30 deaths per 100,000 population at-
ibuted to renal disease per year. This finding has
een fairly consistent through the 1960s. This
eath rate is true for the country as a whole and
r our region. At least five of these 25 to 30 patients per 100,000 presenting with end stage renal disease probably will be candidates for some kind of therapeutic intervention now available. This number suitably might increase as the criteria for selection and techniques change, but most physicians accept the figure of at least five candidates per 100,000 who, by dialysis or transplantation or both, can lead a reasonably comfortable existence. Unless the latter is likely, most centers have been unwilling to initiate these chronic therapies.

What are these diseases that destroy so many kidneys? There are many analyses of thousands of patients presenting in Europe and this country with end stage kidney disease. In most series, glomerulonephritis heads the list. Now, this includes many kinds of glomerulonephritis and, obviously, many different diseases, but so-called glomerulonephritis is the big leader usually accounting for 50% to 60% of cases. The percent attributed to pyelonephritis has been decreasing in recent years, probably because we are changing our understanding of that disease and how often we diagnose it. But, it still is a term we frequently see, and 20% to 25% of cases are often attributed to pyelonephritis. Polycystic kidney disease may account for 5% to 10% in many series. Analgesic abuse is often difficult to diagnose and might be high in some countries. It probably accounts for no more than 5% in most series. Thus, the big three are glomerulonephritis, pyelonephritis and polycystic kidney disease. These are the diseases that bring patients with chronic renal failure to us. Hereditary nephritis, congenital hypoplasia, renal vascular disease, trauma, acute cortical necrosis and others usually each account for less than 5%.

With the figures I have just given to you, you can predict a minimum case load. It is going to be about 5/100,000. Knowing the population of any area, you can make reasonable estimates. Thus, in the tri-state region I showed you, which includes Missouri, Kansas and Southern Illinois, about 300 to 450 patients a year will be good candidates for dialysis or transplantation.

Now, what about the country as a whole? In July, 1973 when the new Social Security Law went into effect, many statistics suggested that about 13,000 people were being maintained on chronic hemodialysis in this country, with 300 on peritoneal dialysis. If you go through the same numbers I have shown you again, you will come up with our national population figures giving the entire country a new case load of about 10,000 per year. In the next few years, perhaps we will be adding numbers of patients per year almost equal to what we previously have been carrying as a total. These are 10,000 patients per year who will now be funded mainly by the United States Government, i.e., the taxpayers—yourselves. They will be considered highly eligible, and this is based on taking only five of those 30 end stage patients per year as good candidates. There may be even more.

Now, it also is estimated that about 2,400 transplants per year also will be performed in this country with the current techniques. For those patients on hemodialysis, coils still lead the way with 50% to 55% of the people on the coils. The flat-plate dialyzers are used less frequently. The hollow fiber is appearing more on the scene.

There are a number of dialysis centers in this region, and many of you do not know where they are. The Regional Medical Program, in Lewis Hall in Columbia makes readily available a list of the centers, the doctors who run them and some idea of the number of beds open there. These dialysis centers will need to provide increasing service in coming years.

Looking at Missouri dialysis activities based numbers of patients on dialysis per 100,000 pop lation in various regions, a discouraging fa emerges. Regional Medical Program analyses sho figures ranging usually from 2.6 to 5.3 per 100,0 in various regions. These figures are very low.

I have said that there is a case load of five p tients per 100,000 population per year who are e cellent candidates for such therapy. Yet, the b we can find in programs which have been going for years is 5 per 100,000 now being carried. Mo of these regions now should be nearer 15 per 10 000. In a recent meeting of nephrology grou from this area, this problem was recognized as major one. What is the explanation? The answ now is really not the availability of beds nor t centers in each area. Most centers do not hav problems in accepting new patients at present. T main problem is that the patients either are n getting to the physicians or they are not being r ferred for evaluation and for the possibility treatment. Some of the centers have launched e tensive public educational programs. We real think that part of the problem is that for ma reasons, the patients are not being identified an are not being referred. This reflects, perhaps part, physician lag in understanding that financin is now easier and that the techniques are better.

What are the estimated costs that you, the ta payer, will be paying? Before the Social Securi Law went into effect, there was a major swing t home dialysis because it is cheaper than cent dialysis. It costs about $10,000 to train patients an buy equipment the first year, but for most patien on home dialysis, costs are near $5,000 per ye once they are at home. However, there are man patients who cannot dialyze at home. They don have the family support or their home conditio are not appropriate. Now that Social Securit funds are available, patients can more readily a ford center dialysis. A swing back to center dial sis is anticipated. In center programs, patients d not have to remodel their homes and they can l others dialyze them at little inconvenience to thei families. There are various kinds of center a proaches. There are so-called limited-care faciliti and self-care facilities.

Now that the finances are available, center dial sis will provide a much better mode of therapy fo many patients. For many who can do home dialysis the greater independence will cause some to elec it. The government may take steps to encourag cheaper home dialysis.

Most patients are treated with peritoneal dialysis or a brief period of time before they enter one f these programs. Many of you wonder why we unch into peritoneal dialysis for a while. We do t to gain time, to study the patients, to evaluate he situation, to make arrangements and to let rterio-venous fistulae mature. Most patients are arried on peritoneal dialysis less than a month. This is common in many centers.

How long are they trained before they go home? n our experience here, it is usually eight weeks.

After we get the patients into the dialysis program, what is next? Well, if there is no living related donor, we hope that someday a cadaver kidney will become available. The Tissue Typing Laboratory of the Pathology Department provides monthly information about all the patients currently waiting for transplantation. It shows their blood type, their HLA antigens, when and if they have had previous transplantations or transfusions and if cytotoxic antibodies are present. The Dialysis and Transplant Committee of the University and VA hospitals meets and reviews this sheet every two weeks and makes decisions as to which candidates are medically suitable for transplantation. tell you this to make you aware that once they are on dialysis, we continue to monitor and discuss the patients on a frequent basis. All of us, including the patients, are waiting for that kidney to come.

After Dr. Montie talks, I will discuss what happens after all these data are entered into a computer to help us decide what to do with an available cadaver kidney. Dr. Montie, what do you do f some unfortunate person with good kidneys uddenly dies?

Dr. Montie: This afternoon, I would like to discuss the selection of living and cadaveric kidney donors and the essentials of renal preservation and then offer some comments referable to obtaining permission to use a patient's kidneys for transplantation.

Related live donor renal transplantation. Before a potential live donor is accepted by a transplant committee, several factors must be carefully evaluated. One of the first considerations is the potential donor's age. Those less than 18 years old are generally felt to be unacceptable, but there is rarely an exception. One such case reported was that of an identical twin who psychiatrists felt was sufficiently mature to donate her kidney at the age of 14. The upper age limit of acceptability for a potential live donor is generally about 50 years. The rationale for using 50 years as the upper age limit is that because the remaining kidney will be unable to undergo compensatory hypertrophy, there is a higher incidence of nephrosclerosis in those donors older than 50 years and that the incidence of complications following nephrectomy is greater in older individuals. However, I know of no reports in which there has been any correlation with the age of a living donor and success of renal transplantation, other criteria be equal.

The medical evaluation of a potential live donor is naturally comprehensive. In addition to general medical studies and careful evaluation of renal function, renal arteriography is essential. The transplant surgeon who is to perform the transplant nephrectomy cannot afford "surprises" in the operating room. The potential donors must have angiographically normal kidneys. If multiple renal vessels are present unilaterally or bilaterally, this must be appreciated. If offered bilateral single renal arteries, transplant surgeons will generally use the left kidney for transplantation because the left-renal vein is longer and, consequently, the renal transplant surgery is technically easier. However, Starzel has proposed that if a young woman is to be the live donor and other factors are equal, the right kidney should be used because of the increased incidence of pyelonephritis and hydronephrosis secondary to pregnancy in this population. If unilateral multiple vessels are present, the kidney with a single renal artery is the kidney of choice. The presence of bilateral multiple renal arteries is not a contraindication to live donor nephrectomy, but it does require careful planning before the actual surgery.

Psychiatric evaluation of a potential live donor is essential since the decision to donate a kidney must be made by an individual without being forced to donate by family pressures. The physician must always give potential live donors the opportunity to say no without having to live with guilt feelings the rest of their lives.

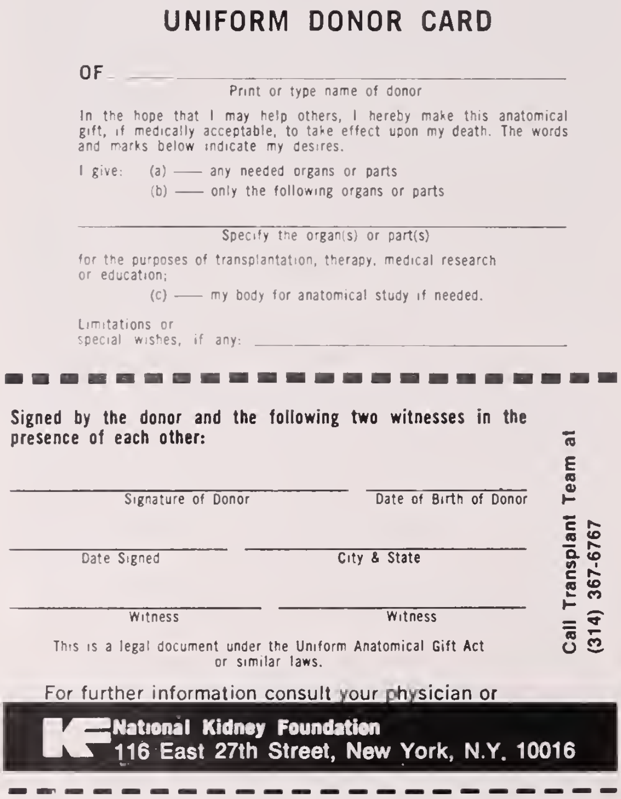
Unrelated living donor renal transplantation. Several centers have used unrelated live donors, most often between husband and wife, but this is probably no longer justified since the results with these transplants have been no better than cadaveric transplants.

Cadaveric renal transplant donors. The use of cadaveric donor kidneys has increased significantly over the past ten years. In 1965, cadaveric transplants comprised 26% of total renal transplants. In 1970, cadaveric transplants comprised 52% of total renal transplants. At present, cadaveric donors out-

TABLE 1
CADAVER DONOR KIDNEY

Brain tumor	26
Brain injury	16
CVA	9
Cardiac	7
Hepatorenal	8
Other	34
	100

number living donors roughly by 2 to 1. The cadaveric donor should not be older than 55 to 65 years of age. This is an arbitrary age limit, but it has been shown in cadaveric donors that age correlates inversely with the ability to achive a successful transplant. Contraindications to using a cadaveric donor are the presence of hypertension, infection and cancer other than brain tumors. Disease states that are relative contraindications are patients with hepatitis and hematologic disorders. The most common source for cadaveric organs is the neurosurgical patient (Table 1). If the potential donor is otherwise suitable, we then require a good urine output and normal renal function. To protect the potential donor while the attending physicians decide if the patient is legally dead and discuss the possibility of organ transplantation with the family, a brisk diuresis is maintained with fluids and diuretics. Vasopressors are to be avoided if possible.



UNIFORM DONOR CARD

OF ______________________
Print or type name of donor

In the hope that I may help others, I hereby make this anatomical gift, if medically acceptable, to take effect upon my death. The words and marks below indicate my desires.

I give: (a) —— any needed organs or parts
(b) —— only the following organs or parts

____
Specify the organ(s) or part(s)

for the purposes of transplantation, therapy, medical research or education;
(c) —— my body for anatomical study if needed.

Limitations or special wishes, if any: ______________________

Signed by the donor and the following two witnesses in the presence of each other:

______________________ Signature of Donor
______________________ Date of Birth of Donor
______________________ Date Signed
______________________ City & State
______________________ Witness
______________________ Witness

This is a legal document under the Uniform Anatomical Gift Act or similar laws.

Call Transplant Team at (314) 367-6767

For further information consult your physician or

National Kidney Foundation
116 East 27th Street, New York, N.Y. 10016

Fig. 1 Front and back of Uniform Donor card.

An acceptable definition of death in a patient with a beating heart has been an area of controversy since the institution of cadaveric organ harvesting. At present, universally accepted criteria are a flat electroencephalogram (EEG), total absence of reflexes other than barbiturate intoxication in a patient, dilated pupils and no spontaneous respiration.

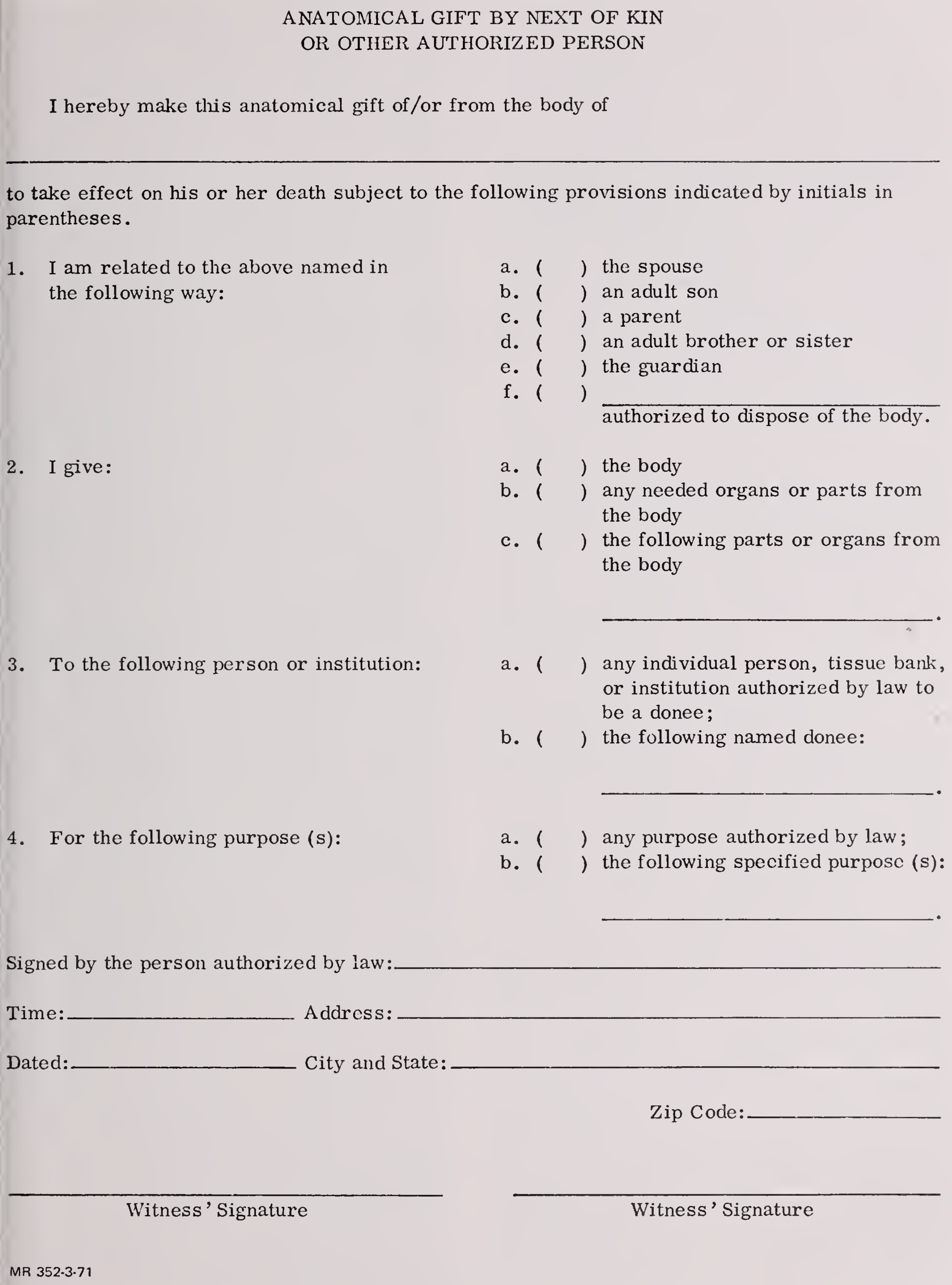
In 1968, the commissioners on Uniform State Laws approved and recommended that the Uniform Anatomical Gift Act be enacted by all states. The philosophy of the act is simply that each individual should be able to control the disposition of his body after death without having his wishes frustrated by anyone, including his next-of-kin. Because of this act, a patient carrying the Uniform Donor card is a legal organ donor in the event of death (Fig. 1). If an acceptable potential donor is not carrying a Uniform Donor card, we must secure permission from the next-of-kin (Fig. 2).

Renal preservation. Preservation of a donor kidney prior to transplantation is critical. With present techniques, we can preserve a kidney for about 72 hours and expect good function if the warm ischemia time is limited to 60 minutes. The least complex method of renal preservation consists of perfusing the kidney with 200 cc to 400 cc of an intracellular hyperosmotic solution and then placing the kidney in iced saline slush (commercially available from Travenol; 50 mg of mannitol are added). This type of perfusion preserves the kidney for about 24 hours. Using a pulsatile perfusion machine, the kidney can remain on the machine for 48 to 72 hours. When the pulsatile perfusion machine is used, we can use perfusion characteristics such as temperature, perfusion pressure, pH and PO_2 of the perfusate to help decide if we have a viable organ for transplantation.

In conclusion, we have reviewed some of the basic aspects of procuring a kidney for renal transplantation. I would like to add that if at any time you have questions regarding a suitable donor, please call either the Urology or Nephrology Divisions.

Dr. Nolph: Thank you, Dr. Montie.

The patient, as you remember, is now on dialysis with pertinent data entered into a computer. What computer? We cooperate with what is called "The Midwest Organ Bank." There are now more than



ANATOMICAL GIFT BY NEXT OF KIN
OR OTHER AUTHORIZED PERSON

I hereby make this anatomical gift of/or from the body of

____

to take effect on his or her death subject to the following provisions indicated by initials in parentheses.

1. I am related to the above named in the following way:
   - a. (   ) the spouse
   - b. (   ) an adult son
   - c. (   ) a parent
   - d. (   ) an adult brother or sister
   - e. (   ) the guardian
   - f. (   ) ____________________ authorized to dispose of the body.
2. I give:
   - a. (   ) the body
   - b. (   ) any needed organs or parts from the body
   - c. (   ) the following parts or organs from the body ____________________.
3. To the following person or institution:
   - a. (   ) any individual person, tissue bank, or institution authorized by law to be a donee;
   - b. (   ) the following named donee: ____________________.
4. For the following purpose (s):
   - a. (   ) any purpose authorized by law;
   - b. (   ) the following specified purpose (s): ____________________.

Signed by the person authorized by law: ____________________

Time: __________ Address: ____________________

Dated: __________ City and State: ____________________

Zip Code: __________

____________________ ____________________

Witness' Signature Witness' Signature

MR 352-3-71

Fig. 2

1,000 recipients registered in this computer system which involves centers throughout the Midwest.

Each tissue-typing laboratory in each center has a small computer terminal. Data from donors can be entered and a list of the best matches by HLA antigen compatibility is instantly produced.

To begin, let me give you an idea of how common transplantation is and how many have been done. Between 1951 and 1972, 12,389 kidney transplants have been recorded in various registries throughout the world. The U. S. A. has been a leader (7,476) and other countries follow closely. Most of these transplantations were done in the last two years of this period. In the years since, the numbers are increasing in leaps and bounds.

When the surgeon harvests a kidney from a donor, that donor is tissue-typed. The HLA antigens of that donor are entered into the computer. Instantly, the computer read-out shows the best matches of recipients. Many of you have seen airplanes flying in and out of Columbia in the middle of the night either to pick up kidneys or to deliver them here.

This is how it happens. Nephrologists at the Kansas City VA Hospital coordinate the efforts of the Midwest Organ Bank. They frequently provide small planes to transport kidneys between centers. The plane lands, the kidney is put on the plane on a portable perfusion machine and the plane flys to that destination where the recipient will be given a transplant. For two of our patients receiving transplants in the past few months, one kidney was flown in from Little Rock, Ark. and the other one was flown in from Kansas City. During the same period, we sent two kidneys via airplane to other centers. This is possible because of information that is immediately available in all the laboratories that are participating and the transportation assistance.

One of the problems has been the final check before the kidney is transplanted or the cross-match. We must be sure that the recipient does not have cytotoxic antibodies to lymphocytes of the donor. And, so with the kidney, we must also transport blood or preferrably spleen or lymph nodes. There is usually a three- or four-hour wait for the cross-matching. In the future, the Midwest Organ Bank system may have serum samples available from all potential recipients at all laboratories. Thus, before we even send the kidney, we can cross-match recipient serum against donor lymphocytes.

What kind of results can we expect from all of this activity? Most series show that patient survival with a living donor transplant and home dialysis are very similar (near 90% for one year and 75% for five years). Home dialysis usually has done better than hospital dialysis which shows only about 55% survival for five years. Why? Because in the past, many of the people who were well enough and healthy enough to do home dialysis were sent home. The hospital dialysis population often represented those who had particular problems. Graft survival with a living donor (80% at one year; 55% at five years) is better than graft survival with a cadaveric graft (40% to 50% at one year to 30% to 40% at five years). For cadaveric grafts, these figures represent a pool of all kinds of matches. If you separate those that are four antigen matches in some series, they may do a little better. Differences between zero, one, two and three antigen matches for cadaveric transplant graft survival have been reported but are not universally accepted.

One of the problems in analysis of HLA antigen compatibility and cadaveric graft survival at most centers has to do with other factors leading to patient selection. For people who are doing well on dialysis, physicians tend to wait for better matches. For the patient who is doing poorly on hemodialysis, the urgency to transplant leads to acceptance of poorer matches. Many of our transplants have been in this latter category because we have had very few of more than one or two antigen similar grafts available. Most of ours have been zero to one antigen similarities and have been in people who are elderly and doing poorly on dialysis.

What are the results at the University of Missouri? Well, we have been doing chronic dialysis for a little over four years and transplantation a little over three years. During that period of time, we have had 40 end stage patients. Of those 40, 18 patients entered and have been maintained only with chronic hemodialysis. Of that 18, eight have died and ten are still doing reasonably well on chronic hemodialysis. Twenty-two have entered the transplant program and have received 24 transplants. All have been cadaveric except one, and two of the 21 cadaveric recipients have received two transplants. Most have been zero to one antigen matches. Of these 21 cadaveric recipients, 11 are still with a functioning graft. Cumulative graft survival over three years approaches 50%. Nine have had the graft subsequently removed (mostly due to rejection) and have gone back to hemodialysis. There were no early postoperative deaths, but six of the 22 patients died at intervals three to eight months after transplantation. Only three deaths were considered transplant related. Two deaths occurred with the graft in place. Of the nine patients who had the graft removed and went back to hemodialysis, five are now on hemodialysis, three have died and one received a second transplant and died thereafter.

The difference in the quality of life for those who have a successful transplant is usually great. You may think that with only 40% to 50% graft survival (national and our results), why not keep them all on dialysis? If you are one of those 50% that make it, however, it seems worth it. We have asked our patients how they would compare the two forms of therapy.

We really hope to have a future grand rounds or conference on this subject. However, one of the patients has summed it up very well. This patient was on dialysis for a long period of time. When asked how he would compare his now successful post-transplant life with hemodialysis, he said, "Since my transplantation, I look before I cross the street."

There are patients, however, who do well on dialysis and are uncertain as to whether transplantation is desired. Some have elected to not undergo transplantation.

We now have two people with three years of graft survival. These two, in fact, are the first two we did. We have a number of people who have had a functioning graft for shorter periods of time. One patient has been maintained for more than 48 months on hemodialysis only. This patient has done very well and is one of those people who really doubt that they want a transplant. Many others on dialysis are active and happy and don't know if they want a transplant.

Usually, patients who are on dialysis and whose neuropathy is not getting better, whose hypertension is a real problem, who are chronically edematous and can't tolerate the diet are usually eager to receive transplants.

We have such a mixed population on chronic hemodialysis; some are eagerly waiting and some are busy and have gone back to work. Some patients are busy holding down full-time jobs while on dialysis. One was a teacher on our faculty until this year when he went to another university. He s active in his teaching role, plays tennis, tolerates dialysis well and is wary about transplantation.

We all will be seeing more and more patients with chronic renal failure in various phases of holding onto life. We hope this session has been helpful to you.

QUESTIONS AND ANSWERS

Dr. Mengel: We have a few minutes for questions.

Question: What are unacceptable problems in donors? What about recipients who are Australia antigen positive?

Dr. Nolph: Kidneys that are infected or from donors with metastatic malignancy are unacceptable. The recipient problem with Australia-antigen positive sera has been studied by different groups. Some have not found differences in patient survival or graft survival in Australia-antigen positive recipients. Others are still concerned of a possible increased risk of developing liver problems on immunosuppression. Dr. Montie, maybe you want to comment.

Dr. Montie: Regarding the cadaver donor, we have greatly altered our criteria for acceptability during the last few years and are depending more and more on perfusion characteristics to decide whether or not the kidney is acceptable for transplantation. Clinical conditions that previously were absolute contraindications are now only relative contraindications.

Question: In the long run, would money for these programs be better invested in preventive programs and preventive research?

Dr. Nolph: The costs of these programs have yet to be realized. They will be enormous—nothing like the cost of Viet Nam per year, but they will still be enormous. Yet, this fact was accepted by Congress, and it is really the first kind of National Disaster Health Insurance. It is going to have an important influence on attitudes toward a National Health Care Bill. The nephrologists, the transplant surgeons and the programs are "on the spot" since what happens in the next few years with this program could set the pace for the kinds of decisions that need to be made by this country regarding all kinds of health care programs. Hopefully, prevention is the answer of the future and will be cheaper. Meanwhile, who knows just how much can we afford?

Dr. Montie: I, personally, feel that very young children and very old adults are poor candidates, and I'm not sure that transplantation is the answer for these people. I think the young adult is your optimal patient. If the patient can go back into society and be productive, he or she is the optimal patient.

Dr. Mengel: I think that there is one other consideration that bears somewhat on this issue; that is how the resources are allocated. I think the most dramatic part of this entire story is the substantial success that is possible with "end-stage" disease. I believe, however, there are two other elements that merit at least equal attention.

The first is that major contributors to the chronic renal disease problem include pyelonephritis, glomerulonephritis and hypertension. The importance of prevention, early recognition and appropriate management cannot be overemphasized. Whether this develops from primary, secondary or tertiary care is not important. What is important is that it must be the *best* possible. In addition, new information must be developed continually in an effort to improve the patient's circumstances.

The second element bearing comment relates to the small number of people who are presently on a chronic renal disease program in our state. It is very unlikely that we are in a part of the world where there is little chronic renal disease. It is most likely that patients are not being referred properly. The total success of care depends on getting the patient to the level of maximum competence required for his particular stage of disease.

In summary, I thank Dr. Montie and Dr. Nolph for taking part in our session.

Thank you.

Acknowledgements: The participants wish to express appreciation to Mr. Sam Smith, Chief of Medical Illustration at the Veterans Administration Hospital and his staff for their technical assistance in taping the Grand Rounds; to Mr. James Shephard, Administrative Assistant to the Chief of Staff at the Veterans Administration Hospital, for his administrative help and to Marjorie Frederick and Yvonne Walker for their secretarial help; and to Dr. Warren Sites and the staff of the Regional Medical Program Offices in Lewis Hall on the University campus for making available most of the statistics.

In Memoriam

Paul C. Wheeler, M.D., 807 Stadium, Columbia, a graduate of the University of Missouri, 1960; member of Boone County Medical Society; age 42; died Feb. 17, 1975.

Ralph D. Stickler, M.D., 711 E. Illinois, Kirksville, a graduate of Washington University, 1925; member of North Central County Medical Society; age 77; died Feb. 23, 1975.

Irl G. Tremain, M.D., 4254 Flora Pl., St. Louis, a graduate of Washington University, 1922; member of St. Louis Medical Society; age 76; died March 7, 1975.

PRESCRIBING INFORMATION
Antiminth (pyrantel pamoate) Oral Suspension

Actions. Antiminth (pyrantel pamoate) has demonstrated anthelmintic activity against *Enterobius vermicularis* (pinworm) and *Ascaris lumbricoides* (roundworm). The anthelmintic action is probably due to the neuromuscular blocking property of the drug.

Antiminth is partially absorbed after an oral dose. Plasma levels of unchanged drug are low. Peak levels (0.05-0.13μg/ml.) are reached in 1-3 hours. Quantities greater than 50% of administered drug are excreted in feces as the unchanged form, whereas only 7% or less of the dose is found in urine as the unchanged form of the drug and its metabolites.

Indications. For the treatment of ascariasis (roundworm infection) and enterobiasis (pinworm infection).

Warnings. *Usage in Pregnancy:* Reproduction studies have been performed in animals and there was no evidence of propensity for harm to the fetus. The relevance to the human is not known.

There is no experience in pregnant women who have received this drug.

Precautions. Minor transient elevations of SGOT have occurred in a small percentage of patients. Therefore, this drug should be used with caution in patients with pre-existing liver dysfunction.

Adverse Reactions. The most frequently encountered adverse reactions are related to the gastrointestinal system.

Gastrointestinal and hepatic reactions: anorexia, nausea, vomiting, gastralgia, abdominal cramps, diarrhea and tenesmus, transient elevation of SGOT.

CNS reactions: headache, dizziness, drowsiness, and insomnia. Skin reactions: rashes.

Dosage and Administration. *Children and Adults:* Antiminth Oral Suspension (50 mg. of pyrantel base/ml.) should be administered in a single dose of 11 mg. of pyrantel base per kg. of body weight (or 5 mg./lb.); maximum total dose 1 gram. This corresponds to a simplified dosage regimen of 1 cc. of Antiminth per 10 lb. of body weight. (One teaspoonful = 5 cc.)

Antiminth (pyrantel pamoate) Oral Suspension may be administered without regard to ingestion of food or time of day, and purging is not necessary prior to, during, or after therapy. It may be taken with milk or fruit juices.

How Supplied. Antiminth is available as a pleasant tasting caramel-flavored suspension which contains the equivalent of 50 mg. pyrantel base per ml., supplied in 60 cc. bottles and Unicups™ of 5 cc. in packages of 12.

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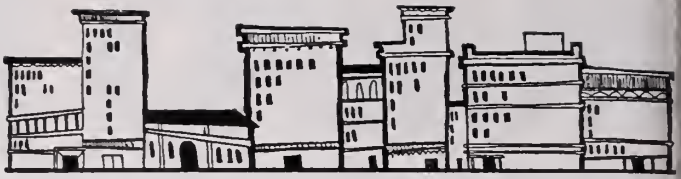
From the Medical Schools



UNIVERSITY OF MISSOURI-COLUMBIA

Dr. Eugene Mitchell, a 1960 graduate of the School of Medicine and recent recipient of the University's Outstanding Alumnus Award, was on the Columbia campus on March 4 to speak during Minority Student Emphasis Week.

Dr. Mitchell is Director of the Homer G. Phillips Hospital in St. Louis and editor of the St. Louis newspaper, *The Argus.* He combines these activities with an active practice of surgery and has been a member of the Admission Committee of the Washington University School of Medicine.

His topic was "The Problems of a Black Physician in an Urban Environment." After the lecture, he participated in a meeting with faculty and student leaders in the School of Medicine where there was a discussion of minority student recruitment and retention.

Seventy-six medical students representing 45 midwestern universities presented results of their research projects at the sixth annual Midwest Student Medical Research Forum held on the Columbia campus on March 5-7. The keynote address was given by *Dr. Robert Stone,* immediate Past-Director of the National Institutes of Health. Another prominent speaker was *Dr. Barbara Bowman,* a leader in cystic fibrosis research. She is chairman of an expanded department at the University of Texas Medical Branch at Galveston that includes human biological chemistry and genetics.

The visiting students were guests in the homes of medical school faculty members during their visit in Columbia. They were guests at a barbecue on March 5. On March 6, they were entertained by the Greene County Singing Doctors at a banquet at the Hilton Inn.

The Medical Center has adopted a Patient Bill of Rights. Hospital director *Joe S. Greathouse, Jr.* stated that this does not reflect a new philosophy, but is intended to remind the public, patients and employees of the basic rights and responsibilities relating to patient care. Each employee has been asked to make a sincere effort to assist in carrying out this institutional objective.

UNIVERSITY OF MISSOURI-KANSAS CITY

John W. Cashman, M.D. has joined the faculty of the School of Medicine as a Senior Docent. Dr. Cashman was in the private practice of Internal Medicine in Kansas City after serving a residency in Internal Medicine with the U. S. Public Health Service Hospital in Seattle, Wash. He returned to the Public Health Service in 1958 and was Chief of the Division of Medical Care Administration at the time Medicare and Medicaid were established in 1965. In 1971, he left the Public Health Service to become Director of the Ohio Department of Health. Dr. Cashman holds a Masters Degree in Public Health from Johns Hopkins University and was an Assistant Surgeon General at the time of his retirement from the U. S. Public Health Service.

Lawrence H. Miller, M.D. will join the faculty of the School of Medicine as Docent in June. Dr. Miller has served a rotating internship and one year of general practice residency at the Good Samaritan Hospital in Dayton, Ohio. He finished a one-year fellowship at Harvard University in Adolescent Medicine in 1972. Since July, 1973, Dr. Miller has served as Director, Adolescent Medicine, Children's Medical Center, Dayton, Ohio.

An award of $25,000 from the Victor E. Speas Foundation has been made to the School of Medicine for the benefit of 80 students. The financial aid program established by this award will be known as "The Victor E. Speas Loan and Scholarship Fund for Students Attending the University of Missouri at Kansas City Medical School." Awards from this fund to students may take the form of grants or loans and will be available to students in all six years of the medical school program.

A *Sabbatical Leave Program* is available for physicians in practice who are able to commit at least one month to learning and teaching full time at the School of Medicine. Duties in this program include observing and demonstrating the best concepts in the practice of medicine to medical students and house staff. Interested physicians may correspond with *Richardson K. Noback,* M.D., Dean of the School of Medicine. The Sabbatical Leave Physician will receive a salary of $2,000 per month.

ST. LOUIS UNIVERSITY

Phi Delta Epsilon fraternity of the School of Medicine conducted the sixth annual children's clinic on March 1 at the St. Louis Veterans Administration Hospital (John Cochran).

Approximately 100 children from the North St. Louis area were given medical examinations in the clinic program sponsored by Morro House, an affiliate of the University.

Morro House was organized in 1968 by undergraduate students to provide remedial tutoring for preschool to sixth-grade children. Each spring, the children and their brothers and sisters are offered the opportunity to have complete medical and dental check-ups.

Medical students of the fraternity conducted the examinations in the outpatient clinic of VA Hospital. School of Medicine faculty physicians who cooperated in the student project included *Dr. Raymond G. Slavin,* faculty advisor to the fraternity and professor of internal medicine; *Dr. Simon Horenstein,* professor and chairman of the Department of Neurology; and *Dr. David L. Simon,* assistant clinical professor of pediatrics.

The medical screening program included a complete medical history, urinalysis, blood pressure, eye and hearing tests. Referrals for follow-up work are made to Cardinal Glennon Memorial Hospital for Children. All of the services were free of charge.

Three faculty members of the School of Medicine have recently been elected officers of the Medical and Dental Staff of St. Mary's Health Center. *Dr. Joseph V. Finnegan,* associate clinical professor of internal medicine, has been elected president; *Dr. Edward M. Wittgen,* assistant clinical professor of orthopedic surgery, was elected vice president; and *Dr. Alan F. Denk,* senior instructor in surgery, is the new secretary-treasurer.

WASHINGTON UNIVERSITY

The National Institute of Arthritis, Metabolism and Digestive Diseases (NIAMDD) has awarded a five-year grant of more than $2.5 million for a Diabetes and Endocrinology Center at the School of Medicine.

The Center will be directed by *William H. Daughaday,* M.D., professor of medicine and head of the Division of Metabolism. He will be assisted by an advisory committee of leaders in diabetic research at Washington University Medical Center: *Paul E. Lacy,* Ph.D., M.D., Edward Mallinckrodt Professor and head of the Department of Pathology; *David M. Kipnis,* M.D., Busch Professor and head of the Department of Medicine; *Franz M. Matchinsky,* M.D., professor of pharmacology; *Anthony S. Pagliara,* M.D., associate professor of pediatrics and assistant professor of medicine; and *William R. Sherman,* Ph.D., associate professor of psychiatry and assistant professor of biological chemistry.

Dr. Simon Horenstein, professor and chairman, Department of Neurology, St. Louis University School of Medicine, supervises two members of the Phi Delta Epsilon medical fraternity as they conduct examinations at the children's clinic held at Veterans Administration Hospital on March 1.

"In providing these funds the NIAMDD has recognized the past strength in diabetes research in this Medical Center and the need to provide important research tools to investigators for even greater progress in the future," Dr. Daughaday said.

The grant will provide five research facilities which will be available to all Medical Center investigators of diabetes-related topics. They are the Clinical Research and Education Facility, Radioimmunoassay Facility, Morphology Facility, Tissue Isolation and Culture Facility and Mass Spectrometry Facility. Diabetes Center researchers will analyze data from current patients of Medical Center physicians.

A formal opening ceremony for the Center is planned for September 8.

Fifty-eight of Washington University School of Medicine's largest class of 127 will begin practicing in St. Louis following graduation in May.

Of the 45% of the class staying in St. Louis, the largest number, 32, will be interning at Barnes Hospital. Thirteen will receive their first year of postgraduate training at the Jewish Hospital of St. Louis and five will be going to St. Louis Children's Hospital.

Two each will be at St. John's Mercy Medical Center, St. Louis University Hospital, and Washington University School of Medicine. One will go to St. Luke's Hospital, and one, who was a dentist before entering medical school, will go directly into the private practice of dental surgery.

Of the 18 students from the St. Louis area in the class, 14 will remain here for their internships.

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Missouri Medicine

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FRED S. GORELICK, M.D., JOHN D. ECKRICH, M.D., *and*
ROBERT ROSS, M.D., *Columbia*

Chronic Arsenic Poisoning—An Elusive and Costly Problem

Case Reports

HRONIC EXPOSURE to arsenic can be expressed by rotean features and, thus, can become an elusive iagnostic problem. Therefore, it is often suspected nly after extensive evaluation and costly hospitaliation. The purpose of this report is to call attention o the problem and its subtle and costly nature. ome aspects of the problem will be illustrated by atient descriptions.

ASE REPORTS

Case #1. A 52-year-old disabled machinist with a istory of adult onset diabetes mellitus and chronic lcoholism presented in May, 1974 with a four-year istory of recurrent abdominal pain leading to three egative exploratory laparotomies. Medical and psyhiatric evaluation led to a diagnosis of depressive eurosis. In July, 1974, he presented again with ablominal pain. Anemia and eosinophilia were noted. In eptember, 1974, he began to complain of paresthesias n his hands and feet, and he had a loss of skin in layers rom the palms of his hands.

A urine "heavy metal screen" was negative at that ime. In October, 1974, transverse striate leukonychia Mee's lines) were first identified. Several weeks later, rsenic levels in his hair and nails by neutron activaion were found to be elevated (40 μg/g; normal up o 1 μg/g).[1] The patient was treated with a course of imercaprol.

No definite source for poisoning was found. There as no significant change in the patient's symptoms ollowing therapy.

Case #2. A 50-year-old chronic alcoholic with hepaitis and cerebrovascular accident (CVA) on the left ide was noted to be anemic in May, 1974. A "heavy metal screen" was obtained because of basophilic stippling of red cells. It was negative. The patient was reevaluated one month later because of progressive anemia, hematuria, renal failure and lower extremity paresthesias. A renal biopsy on that admission demonstrated mesangial capillary glomerulonephritis. Evaluation of hair and nail revealed elevated arsenic levels. No etiology of arsenic intoxication could be identified. He was not treated with chelating agents.

Case #3. A 55-year-old male auto body painter was seen in March, 1974 with a three-month history of nausea, weakness, ataxia, peripheral neuropathy and mental status changes. He was found to have proximal muscle weakness and decreased deep tendon reflexes. Hair and nail arsenic levels were markedly elevated. A change in jobs, which removed him from continued arsenic exposure in his paint shop, led to a disappearance of symptomatology and a return of arsenic levels to normal. He was not treated with chelating agents.

This report directs attention to the physician's difficult problem in diagnosing chronic arsenic intoxication and the fact that it often is suspected only after a major medical evaluation at a significant cost to the patient. The most reliable analytical tool now available is hair and nail analyses by neutron activation, a technique available at the University of Missouri Medical Center. The authors are from the Department of Medicine at the Medical Center.

Discussion

The clinical presentations of arsenic intoxication are well outlined in several major articles and texts.[1-6]

Acute poisoning by the oral route produces severe oral burning, diarrhea, nausea and vomiting and abdominal pain. Circulatory collapse and death may ensue rapidly.[5]

Chronic arsenic intoxication often poses more of a diagnostic problem. The first signs are often "vague" and include paresthesias, weakness, muscle aching and prostration. Gastrointestinal symptoms usually are less prominent in the chronic state. The physical characteristics, which can be found in both chronic and acute poisoning, are subtle. Perhaps the most characteristic are Mee's lines, transverse white stria 1 mm to 2 mm in width appearing above the lunula of each fingernail. Mucous membrane irritation and desquamation of skin on palms and soles also may appear on occasion.[5]

Although our patients demonstrated many of the characteristics of the chronic state of arsenic toxicity, they, as have others, illustrate the delay in diagnosis and difficulty in identifying the source of poisoning (Table 1). Furthermore, the cost to the patient and, thus, the health care system also present major problems in diagnosis.

Several arsenic analysis methods now are available. It should be noted that a "urine heavy metal screen" utilizing the Reinsch reaction[1, 8] is effective only for the detection of bismuth and antimony poisoning in the chronic state. It is useful with arsenic only with extremely high arsenic levels in the acute phase of intoxication.

Spectrophotometric blood analysis is not helpful except in patients with acute intoxication, and even these may be in the "normal" range. There is a wide range of "normal" for urine levels, making these interpretations difficult. Newer spectrophotometric and atomic absorption analyses and more precise establishment of norms for a given population may soon be available.

At the present time, the most reliable analytical tool available is hair and nail analyses by neutron activation. The specimen must be obtained carefully. Hair samples must be cut close to the root and labelled as to proximal and distal ends (for dating purposes). This analytical procedure, along with suggestions for proper collection technique, now are being handled through the University of Missouri Medical Center's (UMMC) Department of Pathology[*] in conjunction with the Trace Metals Laboratory at the University of Missouri. This not only offers a current and dependable analytical technique which has the potential of decreasing both length and cost of patient hospitalization, but it also detects previously missed arsenic intoxications and accurately dates them.

After arsenic toxicity is identified, treatment with chelating agents is favored for acute intoxication. The best treatment of chronic intoxication is not completely settled. The rate and degree of recovery once neurological symptoms are present are at best only fair.[3, 8] It must be emphasized that the most important factor in patient care after the identification of the presence of arsenic intoxication is the identification and elimination of the source.

TABLE 1

REVIEW OF NINE PATIENTS SEEN AT UNIVERSITY OF MISSOURI MEDICAL CENTER FROM 1963-1974 WITH DOCUMENTED CHRONIC ARSENIC INTOXICATION

# of Patients	*Probable Onset of Symptoms to Date of Diagnosis*	*Duration of Hospitalization*	*Cost of Hospitalization*
9	2.5 months (average)	1 month (average)	$5,000 (average)

Summary

Chronic arsenic intoxication presents a difficult diagnostic problem to the physician. It is often suspected only after a major medical evaluation at significant cost to the patient. Hair and nail neutron activation analysis of arsenic offered at the UMMC provides a dependable technique for diagnosing arsenic toxicity. Removal of the arsenic source is the one known beneficial therapeutic endeavor.

Acknowledgements: The authors wish to express appreciation to Charles E. Mengel, M.D., for his advice and interest and to Mrs Janet Shipley for technical assistance.

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[*] Referral to Drs. John Townsend and Brian Pape, c/o Dept. of Pathology, UMMC, (314) 882-8761. This also is available through select other medical referral laboratories.

GERALD V. CUPP, M.D., LINLEY E. WATSON, M.D.
and RICHARD H. MARTIN, M.D., *Columbia*

Concealed Conduction in a Case of Lev's Disease

Case Report

A case with fibrocalcific changes in the conduction system with certain unusual features is reported in this article. Intermittent complete heart block is present above the bundle of His or bundle branch level resulting in narrow QRS complexes. Also, evidence for concealed conduction is observed with premature His depolarizations causing simulated intermittent first degree AV block. Dr. Cupp is a Postdoctoral Research Fellow, Department of Medicine, Division of Cardiology, University of Missouri Medical Center; Dr. Watson is Chief, Cardiovascular Laboratory, VA Hospital; and Dr. Martin is Director, Division of Cardiology, Medical Center.

Concealed conduction has received much interest in the literature since its initial description by Langendorf and Mehlman,[1] but its presence has not been previously associated with the fibrocalcific degeneration described by Lenegre, Yater and Lev.[2–5] Postmortem examination of the conduction system in Lev's and Lenegre's series revealed calcification frequently present at the junctional-bundle branch level. The majority of the patients so described had complete heart block secondary to bilateral bundle branch block with wide QRS complexes. A fewer number had disease at the junctional level with blocks resulting in narrow QRS patterns. We recently studied a patient with syncope who had calcification in the cardiac skeleton and who simulated intermittent first degree block resulting from concealed premature junctional depolarizations. This combination has not been previously reported.

Case Report

A 44-year-old man, an insurance manager, was admitted to the Coronary Care Unit (CCU) because of syncope. On the day of admission, the patient was playing ping-pong with his wife when he lost consciousness and fell to the floor. He remained unconscious "for only a few seconds" and, upon awakening, did not report headache or neurological symptoms. For two to three years prior to admission, he had experienced occasional episodes of transient dizziness with dyspnea but had never lost consciousness. The patient had no other significant past medical history and was taking no medication.

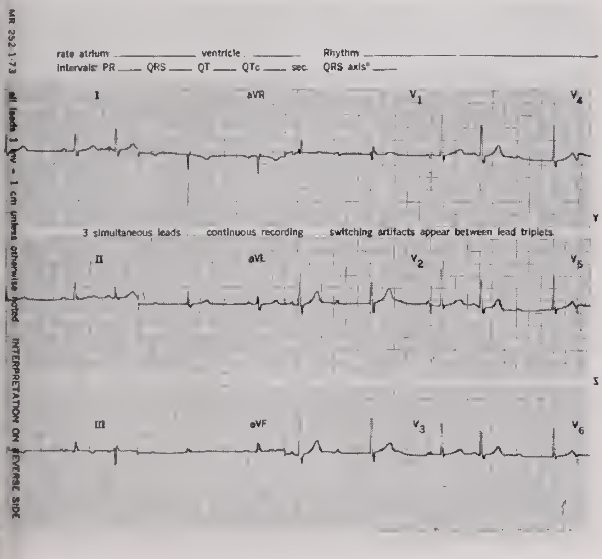
MR 252 1-73
all leads 1 mv = 1 cm unless otherwise noted
INTERPRETATION ON REVERSE SIDE
rate atrium ventricle Rhythm
Intervals: PR QRS QT QTc sec QRS axis°
I
aVR
V1
V4
3 simultaneous leads . . . continuous recording . . . switching artifacts appear between lead triplets
II
aVL
V2
V5
III
aVF
V3
V6

Fig. 1 Electrocardiogram taken on admission.

On physical examination, the blood pressure was 130/80 in both arms and the pulse rate was irregular at 76/min. Otherwise, results of physical examination were normal. Complete blood count (CBC), blood urea nitrogen (BUN), electrolytes, glucose (both fasting and two-hour post-prandial) and urinalysis were normal. The electrocardiogram (ECG) taken on admission (Fig. 1) showed an incomplete right bundle branch block and sudden, intermittent PR prolongation. The chest x-ray showed a normal size heart with calcification localized in the area of the mitral annulus and/or the fibrous trigone best demonstrated by posteroanterior (PA) and lateral tomograms (Fig. 2). On the second hospital day while being monitored, the patient suddenly became lightheaded. The rhythm strip, illustrated in Fig. 3, was obtained during the

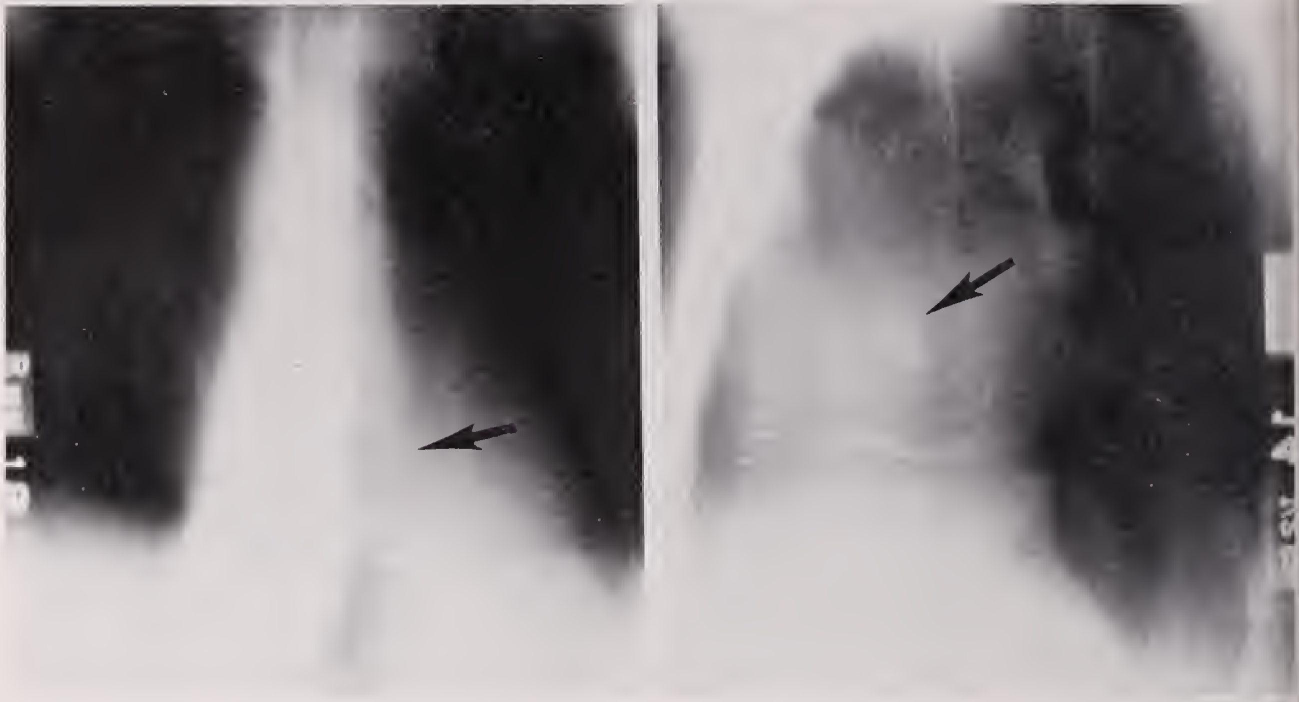

Fig. 2 Calcification is anterior to the pacemaker electrode in the lateral view, but it is not well demonstrated in AP view.

episode and showed normal sinus rhythm followed by block in A-V conduction with no escape mechanism. The patient was taken immediately to the catheterization laboratory where a His bundle electrogram (HBE) was recorded and atrial stress pacing was performed in which techniques previously described[6–8] were used.

Findings

The conduction abnormalities documented during the HBE revealed multiple abnormalities of impulse transmission through the junctional region. These ranged from sinus rhythm with normal AH and HQ intervals shown in the top half of Fig. 4 to intermittent entrance block demonstrated in the lower portion. The patient experienced no symptoms prior to these conduction difficulties, but he did become lightheaded during each episode. The onset of the block was the same in each instance with sudden absence of ventricular response to normal sinus rhythm. No examples of Mobitz I or II block were recorded.

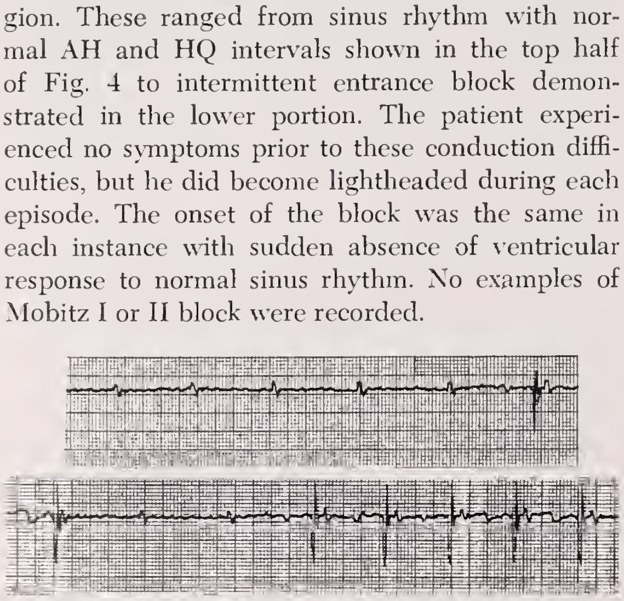

Fig. 3 Continuous rhythm strip showing complete AV block with junctional escape.

The admission ECG and rhythm strips obtained in the CCU showed random PR prolongations. An example is given in Fig. 5. This type of prolongation can be explained by either spontaneous high degree AV block with a junctional escape mechanism or by a preceding concealed premature junctional beat (PJB). The possibility that this could be caused by a concealed PJB is indirectly supported by the presence of conducted premature junctional beats with the subsequent PR prolongation recorded during the study (Fig. 6). The Lewis diagram depicted in that figure illustrates how a concealed PJB at the indicated point could explain the PR lengthening.

More direct evidence for concealed PJBs was the recording of premature His spikes (H^1) that were nonpropagated to the ventricles and were not conducted retrograde to the atria (Fig. 7). These were followed by normal P waves that were either delayed through the junctional region or not transmitted at all with a prolongation of the AH interval from 120 msec to 330 msec. The His extrasystole did not appear to be related to the preceding cycle length and no parasystole could be demonstrated. Minor differences in catheter position made marked changes in H^1 polarity and configuration.

Sinoatrial function and atrial conduction were consistently normal. Sinus node recovery time was normal following both ventricular pacing and

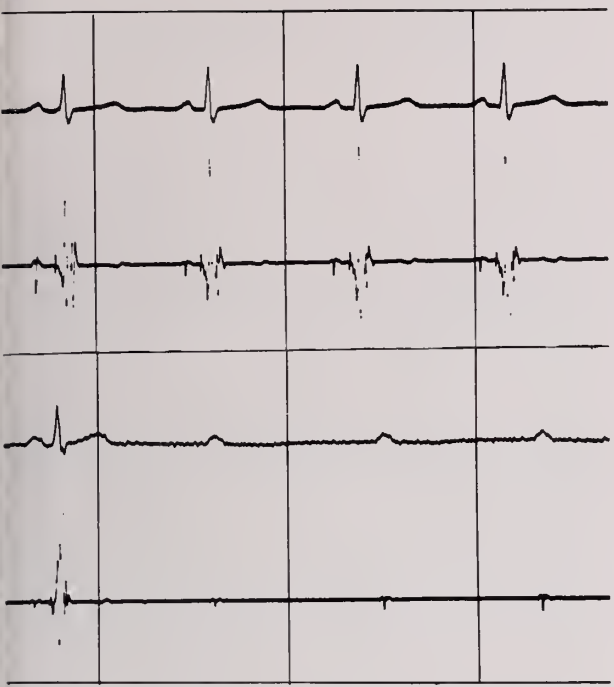

Fig. 4 Portions of the HBE show no His depolarization following any of the nonconducted P waves. This indicates the level of block to be at least proximal to the His bundle. A-H interval = 82 msec, H-V = 31 msec.

right atrial stress pacing. Retrograde conduction was demonstrated to be normal during pacing. The PR interval lengthened appropriately during atrial pacing and AV conduction remained intact during the entire three minutes.

Discussion

Concealed conduction$^{9-10}$ was first described by Langendorf *et al* in 1947. In that report, a patient was presented with typical PJBs followed by PR prolongation and occasional block of normal P waves due to concealed conduction of the PJB with both antegrade and retrograde block. There are certain similarities between Langendorf's case and the present report. The presence of PJBs with occasional retrograde conduction is common to both as is the presence of slight QRS aberrancy after many of the prolonged PR intervals.

Rosen^{11} described premature His bundle depolarizations in a patient with "pseudo AV block" and normal AV conduction. The presence of the nonpropagated His extrasystoles (H^1) was used to explain the mechanism of concealed conduction. He pointed out that the proximity of H^1 to the subsequent P wave was inversely proportional to the duration of the PR interval. Unfortunately in our report, insufficient data are present to recon-

(Continued on page 193)

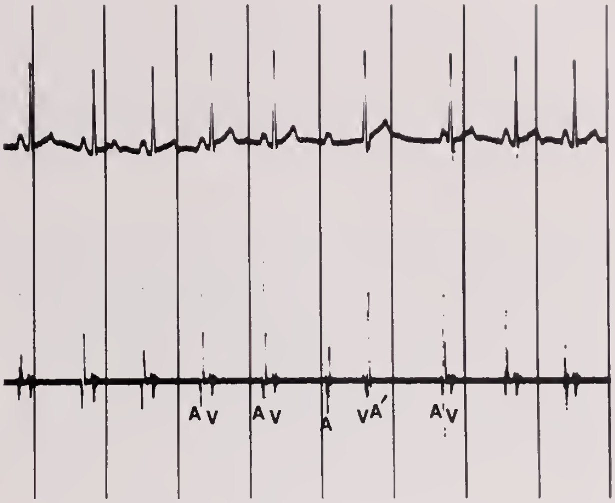

Fig. 5 Intra-atrial tracing. Normal sinus rhythm is present for the first five beats with sudden PR prolongation on the sixth. This is followed by a junctional escape beat with a retrograde P wave (A'). The next PR interval is short and may or may not be conducted.

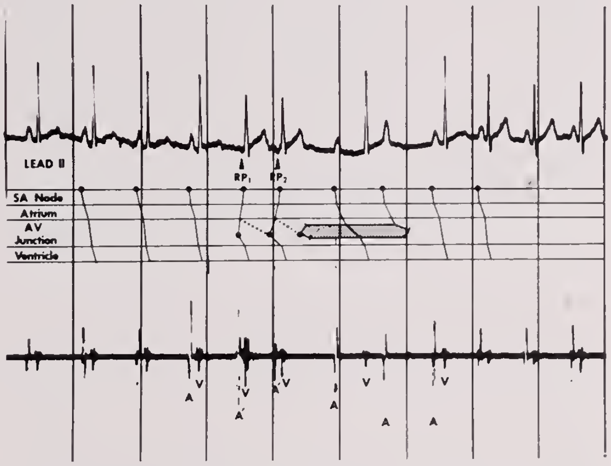

Fig. 6 Intra-atrial recording with ladder-gram shows two conducted premature junction beats with a hypothetical concealed third beat. The interval between the second retrograde P wave (RP$_2$) and the subsequent P wave is equal to or longer than any previous cycle length and is ample time for all parts of the conduction system to repolarize.

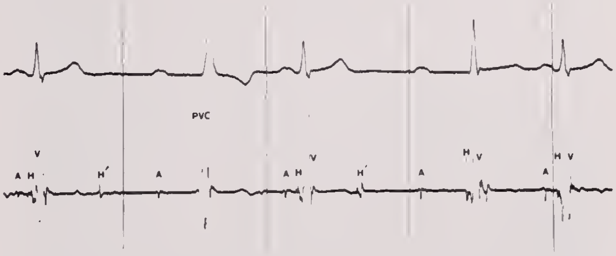

Fig. 7 Example of H^1 recorded during HBE. The atrial rate is regular. The P wave following the first H^1 is delayed with a PVC occurring. The second H^1 causes the next PR interval to be prolonged (140-330 msec) but this P wave is probably conducted.

DAVID L. SMITH, M.D., ***Columbia***

The Newer Cephalosporins

With the introduction of the cephalosporins in the early 1960s, a major new class of antibiotics became available. The purposes of this paper are to compare and contrast the "older" versus the "newer" cephalosporin derivatives.

Older Cephalosporin Derivatives

Cephalothin (Keflin)—(IV, IM)

This was the first of the cephalosporins to be marketed. Its rapid acceptance and widespread use was due to several factors: its usefulness in penicillin sensitive patients, its spectrum against gram positive cocci including penicillinase producing staphylococci, its gram negative spectrum, the relative lack of toxicity and its good penetration into soft tissue and urine. Soon after the introduction of cephalothin, the following major disadvantages became obvious:

1. It was restricted to intravenous use because of the attendant pain on intramuscular administration.
2. It has a tendency to cause thrombophlebitis.
3. It lacks an oral preparation.

Efforts to counteract these disadvantages produced the next three derivatives.

Cephaloridine (Loridine)—(IV, IM)

This was designed to be a well tolerated intramuscular drug. Unfortunately, the nephrotoxicity associated with this agent has forced dose limitation and severely curtailed its usefulness.

Cephaloglycin (Kafocin)—(Oral)

This was the first orally absorbed cephalosporin. Its poor absorption restricted its use to urinary tract infections where therapeutic urine levels could be obtained.

The cephalosporins were introduced in the 1960s. The author compares the old and new derivatives to assign to a place in antibiotic therapy. Dr. Smith is Assistant Professor of Medicine and Head of the Infectious Disease Section of the Division of Pulmonary and Environmental Medicine, University of Missouri School of Medicine.

Cephalexin (Keflex)—(Oral)

This is the second oral agent to be marketed. Its good absorption extended the use of oral cephalosporins to include pneumonias and other soft tissue infections.

Until 1974, these were the available cephalosporin derivatives. Within the past 12 months, several new cephalosporin agents have been introduced. An attempt will be made here to assign them a place in therapy, i.e., do they represent true therapeutic advances or minor molecular manipulations akin to the plethora of thiazide derivatives which appeared in the 1960s. In making these judgments, some of the important criteria should be the following:

1. Improved therapeutic spectrum. None of the new agents meets this. All have spectra virtually identical to the parent compound cephalothin.
2. Decrease in undesirable side effects.
3. Better absorption or penetration or both into certain parts of the body, i.e., cerebrospinal fluid (CSF).
4. Decreased cost.

Newer Cephalosporin Derivatives

Cefazolin (Ancef, Kefzol)—(IV, IM)

Its cost is comparable to cephalothin. It achieves good concentrations in serum and urine, and it penetrates into CSF better than cephalothin. It also is said to have less tendency to produce thrombophlebitis and to be relatively painless on intramuscular administration. The major advantage it possesses over cephaloridine is its lack of nephrotoxicity in both laboratory animals and in clinical trials. Thus, because of its comparable efficacy and lack of renal toxicity, it should replace cephaloridine as the intramuscular cephalosporin of choice. Although it is being promoted as an intravenous alternative to cephalothin, enough experience has not been gathered to recommend it with equal confidence. It may be useful in the patient who has shown a strong tendency to develop thrombophlebitis on cephalothin.

Cephapirin (Cefadyl)—(IV, IM)

This is another parenteral derivative which has not been observed to cause nephrotoxicity. It does not seem to be a major addition for the following reasons:

1. Its efficacy and safety are comparable to that of cefazolin, but the pain on intramuscular administration is much greater. Thus, it is not likely to replace cefazolin for intramuscular use.
2. It is promoted as causing less thrombophlebitis, yet the limited experience with this agent does not allow one to recommend this drug to replace cephalothin. Its place in therapy (if it attains a major one) would seem to be as a possible alternative to I.V. cephalothin, if additional experience confirms its efficacy and safety and if the decrease in thrombophlebitis is real.

Cephradine (Anspor, Velosef)

This drug is a minor modification of the cephalexin molecule. It behaves in a like manner. This agent represents no therapeutic advance. At present, it cannot be recommended with the same confidence as cephalexin because of lack of clinical experience. If subsequent use proves its efficacy comparable to cephalexin, they would be equally desirable.

Summary

Various cephalosporin derivatives, old and new, are reviewed with a view toward assigning them to a place in antibiotic therapy. The following conclusions seem justified:

1. Cephalothin (Keflin) remains the intravenous cephalosporin of choice.
2. Cefazolin (Ancef, Kefzol) should supplant cephaloridine (Loridine) as the intramuscular cephalosporin of choice.
3. Cephalexin (Keflex) continues as the oral cephalosporin of choice.
4. Cephaloglycin (Kafocin) because of its poor absorption and cephaloridine (Loridine) because of its nephrotoxicity are of historical interest and have no place in modern therapy. They should be deleted from hospital formularies and, hopefully, withdrawn from the market place.

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Lev's Diseases

(Continued from page 191)

firm these conclusions.

Much has been written about the patterns of fibrocalcific conduction system degeneration. It is a poorly understood process which usually involves both bundle branches and may initially present as Stokes-Adams attacks. The patients are usually free of coronary artery disease, congenital defects or any other demonstrable cardiac disease. Typically, these people have electrocardiographic evidence of bilateral bundle branch block or of trifascicular block. Our patient presented prematurely in the spectrum from normal conduction to complete heart block in that he demonstrated no criteria for fascicular block. The HBE shows the conduction abnormality to be intranodal and above the bundle of His or bundle branch level. The calcification that is present is demonstrated to be in the mitral annulus-fibrous trigone region by both cine fluoroscopy and tomograms. Whether or not the fibrocalcific changes are present in the region of the junction cannot be documented.

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JOHN A. BYER, M.D. *and* **JAMES D. DEXTER, M.D.,** ***Columbia***

Hypoglycemic Migraine

Hypoglycemia has been recognized in association with headache for many years. It is less well appreciated as one of many precipitating factors in certain patients with migraine headache. Various theories have been proposed to explain the precipitating event in migraine. In 1933, McDonald Critchley included a "dietetic" type in his classification of migraine.[1] Gray and Burtness described the use of orange juice to prevent headache in early morning migraine.[2] Blau and Cummings noted that six out of 12 subjects had an attack of migraine during a day of fasting.[3] Blau and Pike noted that five out of 36 patients with both migraine and diabetes had marked reduction of migraine with the onset of control of diabetes.[4] They further reported that six patients had migraine following a missed meal. In 1966, Pierce reported that only one out of 20 migraine patients had a migrane identical with their usual symptoms during an insulin produced hypoglycemia in the range of 20 mg. %.[5]

In addition to glucose metabolism, the metabolism of lipids has been investigated. Hockaday *et al* studied blood glucose, free fatty acid, acetoacetate, 3-hydroxybutyrate, glycerol, lactate and pyruvate for eight hours after the administration of 50 gm of glucose following a ten-hour fast.[6] They suggested that the metabolism of free fatty acids, but not of adipose tissue fat, differs between the groups of migraine patients whose headaches are precipitated by hypoglycemia and those who are not affected by hypoglycemia.

Blau *et al* reported on serum levels of transketolase, cortisol, 5-hydroxyindoleacetic acid, catecholamines and ketosteroid urine levels.[7]

In 1949, Charles Wilkinson reported that 11 patients benefitted by treatment with a diet of 150 gm of protein, 190 gm of fat and 75 gm of carbohydrate.[8]

This paper reports results of treating migraine patients with a six-feeding, high-protein, low carbohydrate diet.

In this study of 13 patients with classical, common or cluster migraine, the data suggest that a frequent-feeding, high-protein, restricted-carbohydrate diet may be effective in reducing the severity and frequency of migraine attacks in those patients who have evidence of transient hypoglycemia on five-hour glucose tolerance testing. Dr. Byer is from the Department of Neurology and Dr. Dexter is from the John M. Dalton Research Center and Department of Neurology, University of Missouri School of Medicine.

Materials and Methods

The patients' ages range from 22 years to 55 years and include four men and nine women. The classification of the National Institute of Neurologic Disease and Blindness drug trials for headache was employed.[9] Patients with intractable headache were referred to the University of Missouri Neurology Clinic. Common migrane, diagnosed in eight patients, was the most frequent type of migraine. Two patients had pre menstrual migraine, one patient had cluster migraine and the remaining two patients had classic migraine. One patient (# 8) had central scotoma and one patient (# 9) had fog in front of his eyes prior to headache. One patient (# 10) had fortification spectrum on his peripheral vision accompanied by numbness and weakness. One patient (# 1) had bilateral temporal throbbing pain with flashing light. The other patients had no other neurological abnormalities or aura. All of the older patients had onset of headaches early in life. All patients had hypoglycemia as manifested by serum glucose of less than 65 mg/100 ml or a rapid fall in blood sugar during the five-hour oral glucose tolerance test.

No migraine patients with a normal glucose tolerance test were included in this study as controls, but it should be noted that three patients stopped their diet and had exacerbation in headache frequency. Glucose tolerance was established by a routine five-hour, 100 gm, oral, serum glucose tolerance test done in the clinical laboratory. No preparatory diet was given prior to the test. Most of these patients had symptoms of headache during the glucose tolerance test.

All patients were treated with a diet consisting of 1,000 calories to 2,500 calories. The calories were distributed in a six-feeding diet in a ratio of 2-1-2-

TABLE 1

				Family	Serum Glucose Tolerance Test/Hr.									
Patient	Type	Sex	Age	History	F	½	1	2	3	4	5	Diet	Meds.	Results
# 1	Co M	F	34	+	91	182	190	142	100	45	72	1,800	Ergotamine and Amitriptyline	3+
# 2	Co M	F	42	+	111	202	214	156	106	65	86	1,300	Ergotamine	2+
# 3	Co M	F	29	+	93	173	185	116	53	76	88	1,400	None	3+
# 4	Co M	F	50	+	90	160	120	82	43	66	90	1,800	Ergotamine	3+
# 5	Co M	M	55	+	112	175	174	103	45	85	80	1,800	Amitriptyline	3+
# 6	Co M	F	42	+	86	114	85	88	62	90	—	1,200	Ergotamine	3+
# 7	Co M	F	33	+	165	195	197	172	86	125	132	1,800	Phenformin	3+
# 8	Co M	F	22	0	97	92	88	90	48	84	84	1,600	Barbiturate	3+
# 9	Cl M	M	38	+	94	135	140	63	51	76	96	2,400	Methysergide	3+
#10	Mix	M	23	+	100	195	175	100	55	75	80	1,850	Diazepam	3+
#11	Mix	F	33	+	91	142	122	108	63	65	77	1,800	Barbiturate	3+
#12	PreM Mig	F	49	+	90	137	140	106	60	80	90	1,400	Conjugated estrogen	1+
#13	PreM Mig	F	28	+	90	155	118	82	80	53	87	1,600	Diazepam	3+

Co M = Common migraine.
Cl M = Classic migraine.
Mix = Muscle contraction, common migraine.
PreM. Mig. = Premenstrual headache.

1-2-1. The protein-fat-carbohydrate ratio was 20:45:35. A dietitian from the Nutrition Department saw all patients and explained the diet to them. The diets of less than 1,500 calories were prescribed for patients who were trying to lose weight as well as control headache.

The diagnosis, sex, age, family history, glucose tolerance test, total calories in diet, medical regimen and response to theropy are listed in Table 1. "One plus" relief is defined as very little or questionable benefit. "Two plus" relief is better than 50% improvement. "Three plus" relief is greater than 75% improvement. Improvement is defined as decrease in severity, frequency or both.

Results

Ten patients had greater than 75% relief. Two patients had greater than 50% relief and two patients received very little benefit. One of the patients with pre menstrual headaches had good relief of headaches, but the other patient with this type of headache had very little benefit.

This diet regimen did give improvement and lessened the severity as well as frequency of headaches. It should be emphasized that none of these patients was headache-free. It soon became apparent that many patients had difficulty following the diet. This was seen as the cause of failure in Patient # 5. As the follow-up was extended, several other patients were unable or unwilling to continue their diet and were having more frequent headaches.

Discussion

In 1933, Critchley noted that quantity and regularity of diet are more important factors than quality in production of migraine.[1] He observed that many attacks occurred after physical exertion or starvation and that the administration of glucose, particularly in children, may implicate a transitory hypoglycemia as a causative factor in the production of migraine. He noted that relief could be obtained by administering glucose as soon as notice of an attack is present or that attacks may be prevented by administration of glucose between meals. Blau and Pike reported in 1970 that in 36 patients with both migraine and diabetes, five patients lost their migraine completely or had a marked reduction in their attacks with the onset of the control of diabetes.[4] In four other patients, nocturnal-type hypoglycemia precipitated migraine headache. Of the 27 remaining patients, six noted that fasting or missing a meal sometimes provoked an attack of migraine. Blau *et al* reported that six out of 12 subjects had an attack of migraine during a day of fasting.[3]

They proposed that some patients have migraine triggered by persistent hypoglycemia and that eating is an obvious and easy method of preventing attacks. Gray and Burtness reported in 1935 that a 38-year-old obese woman with migraine and a falling blood sugar from the three- to four-hour level of 122 mg/100 ml to 76 mg/100 ml. She was treated with 100 cc of orange juice daily at 4 AM and was headache-free for three months. Four other patients had similar good results with this therapy. They stated that "blood sugar need not fall to that which is ordinarily associated with insulin shocks in order to be significant in persons disposed of headaches." The belief that a relative hypoglycemia is an accompaniment of headache in these patients is based on (1) appearance of headache at the time the blood sugar level is found to be or could be expected to be low, (2) the avoidance of headache by the taking of carbohydrate containing food several hours preceding the expected headache and (3) "low" or "flat" type of blood sugar curve after the ingestion of 1.5 gm of glucose per kilogram body weight. The usual blood sugar values in these patients during attacks were from between 70 mg/100 ml and 90 mg/100 ml. These authors then studied the records of 111 patients with a low glucose tolerance curve and found that of these patients, 38 or 42% reported headaches as a major admission complaint. Only 6.9% of diabetic patients selected at random reported headaches.

Other hormones and metabolites have been studied in conjunction with falling levels of blood glucose. In 1966, Blau *et al* reported on the levels of transketolase, cortisol, 5-HIAA and ketosteroids of urine.[7] A slightly low 17-ketosteroids and ketogenic steroids in one person and raised cortisol levels in another person were noted. On the fasting day, the catecholamine level was lower than on the control day without fasting. There was no significant change in blood cortisol with one exception and that was in a person who was taking oral contraceptives. Urinary ketogenic steroids during the fast day were unchanged from that of the control day.

The role of lipids in migraine was studied by Hockaday *et al* in 1971.[6] They reported ten migraine patients with a history of attacks after or preceded by undue hunger in which the blood glucose, free fatty acid, acetoacetate, glycerol, pyruvate and lactate were measured serially for eight hours after administration of 50 mg of glucose following a ten-hour fast. An attack of migraine began during the test period in six of 12 patients. There was no difference in glucose levels between the patients who experienced migraine and those who did not. The serum glucose levels were not falling before the onset of headache. In a patient who experienced migraine, free fatty acid levels rose very much higher than in patients who did not experience headache. They concluded that the metabolism of free fatty acids and of adipose tissue fat differs between these two groups of migraine patients in that free fatty acid levels are an associated abnormality, if not a direct cause, of the migraine headache.

In 1949, Charles Wilkinson reported the benefit of a high protein therapeutic diet in migraine patients with hypoglycemia.[8] He reported that in 92 patients seen in more than a 17-month period, 11 had headaches of migrainoid nature that seemed to be associated with spontaneous hyperinsulinism. All of these patients had improvement or complete relief following therapy of 150 gm of protein, 190 gm of fat, and 75 gm of carbohydrate diet.

Pierce reported in 1966 that insulin-induced hypoglycemia in the range of 20 mg% produced symptoms identical with classical migraine headache in only one patient out of 20 migraine patients studied.[5] He concluded that the rapidly falling blood glucose of approximately 50 mg% in 30 minutes or moderately severe hypoglycemia is sufficient to induce migrainous symptoms in only occasional migraine patients. They did not believe that the attacks related to the rapidity of fall in the venous blood sugar but that other, probably more complex metabolic factors must be involved.

CONCLUSION

This study demonstrated that some migraine patients who have demonstrable hypoglycemia or rapid fall in blood glucose on glucose tolerance testing did receive benefit from a six-feeding, high-protein, low-carbohydrate diet in that headaches were less frequent and less severe while on this dietary regimen. Not all of our patients' blood glucose fell below the limit of 60 mg/100 ml. Some have a flat curve as does Patient # 12, while others, such as Patient # 2, dropped from 195 mg/100 ml to 55 mg/100 ml in two and one-half hours.

It is not possible to state from these data that the precipitating factor of migraine headaches is either the rate of fall of blood glucose or the absolute value of blood glucose. There may be other factors which have been mentioned previously which precipitate the abnormal vascular dilatation of migraine that are associated with low blood glucose. It is not our intent to describe the mechanism of the phenomenon but, rather, to draw attention to the successful treatment of some patients with migraine headaches with a low carbohydrate, high-protein, calorie-restricted, six-feeding diet.

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Continuing Education Coming Events

April 16-17	**Symposium: Family Practice** Postgraduate Education K.U. Medical Center, Kansas City, Kan.
April 18	**Symposium: Infectious Diseases** Postgraduate Medical Education K.U. Medical Center, Kansas City, Kan.
April 21-23	**Symposium: Anesthesiology** Postgraduate Medical Education, K.U. School of Medicine Alameda Plaza Hotel, Kansas City
April 24-25	**Seventh Annual Matt Weis Symposium: Infections in Obstetrics and Gynecology** Dept. of Obstetrics and Gynecology St. John's Mercy Medical Center, St. Louis
April 25-27	**Annual Meeting** Missouri Society of Anesthesiologists Tan-Tar-A Lodge, Osage Beach
May 1-2	**Conference: Clinical Approach to Allergic Disorders** Busch Memorial Center St. Louis U. School of Medicine, St. Louis
May 1-3	**Current Concepts in Medicine and Surgery—1975** Departments of Surgery, Jewish Hospital of St. Louis and Washington U. School of Medicine Steinberg Amphitheatre, Jewish Hospital, St. Louis
May 7	**13th Annual Pediatric Seminar: Allergy and Immunology** Baptist Memorial Hospital, Kansas City
May 8-9	**Symposium: Cardiovascular Diseases** Postgraduate Education K.U. Medical Center, Kansas City, Kan.
May 12	**Citywide Radiology Conference: Evaluation of Genitourinary Disease** Mallinckrodt Institute of Radiology, St. Louis
May 20	**Upper Respiratory Infections in Children** N.W. Mo. Chapter, Missouri Academy of Family Physicians and K.U. School of Medicine Moila Temple, St. Joseph

(Continued on page 207)

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President's Message

This is the last time you will see a picture of my face on the President's Page. It seems almost impossible that a year has gone by since I first wondered what to write about. For me, it has been a good year. I have been invited to every area in the state and have enjoyed going. In fact, I believe the people I have met and the friends I have made represent the high point of the year. Without qualification, I can state that the physicians of Missouri and their wives are the finest, friendliest bunch of men and women you could find anywhere. Long after other memories of the past year have faded, the picture of the people will still be bright in my mind.

James C. Cope, M.D.

Without our staff, the President or the organization cannot function. It doesn't take long to develop a real dependence on them, and each has been pleasant and helpful—often beyond the call of duty. I will not mention any names because I cannot mention them all, and to leave out a single one would be an injustice for each performs magnificently at his own job.

I have been impressed with the sincerity and expertise of our various Commission Chairmen and members. This is not the place to recount their manifold accomplishments, but these accomplishments are significant.

It has been my pleasure to receive a number of personal communications from members. Some of these have been letters of encouragement; others were in disagreement with either my actions or established policy of the organization. All were thoughtful; all were making an attempt to be helpful. To a person who receives too many form letters and government bulletins, all were immensely refreshing. I tried to answer each of them with a personal letter.

So now, Good-bye. But, before I leave, let me express my profound belief that the medical profession will not only survive the attack by the federal bureaucracy but will, in the end, prevail if, and only if, we keep the faith as physicians and healers of the sick. We must be active in politics as good citizenship demands. We must become and remain knowledgeable about government programs and intrusions. But, when the final Armageddon comes and we will allow ourselves to be pushed no further, our power will exist because none of us has betrayed the trust of our profession and, in the minds and hearts of our patients, we have remained the good and great physician.

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Woman's Auxiliary

"Beginning our second half-century" will be the theme for the Auxiliary Annual Convention to be held in St. Louis this month. By reviewing reports from the first half-century, it is easy to see that we have a heritage of which we can be proud. Reports given at the convention will mark the progress made during the past year. We hope to show an increase in membership, unequalled totals in donations to AMA-ERF and to the Missouri State Medical Foundation, community involvement in many areas, promotion of medical careers, knowledgeable interest in legislation and many MMPAC members. You can see that the Woman's Auxiliary is a many-faceted organization.

Mrs. George J. Lytton
President

We invite all MSMA members to join us at one of the highlights of the convention—the Public Affairs Breakfast to be held on Saturday morning. Featured as speakers will be Dr. Frank J. Jirka, Jr., a member of the AMA Board of Trustees; the Honorable Richard Rabbitt, Speaker of the Missouri House of Representatives; and Dr. Hubert Ritter, Chairman of MMPAC. This is an opportunity for you to have breakfast with your wife and to enjoy outstanding speakers.

With the convention comes the end of my year as state president. It has truly been an honor and a privilege to serve. Travels across the state have proved that doctors' wives are very special people. All members of the Board have contributed to the success of the year by working very conscientiously. It has been a special joy to work and travel with the incoming president, Mrs. William R. McPhee of Clay County. Hers will be the new face to appear on this page, and she will do an outstanding job.

The encouragement and interest of the MSMA have been most appreciated. We thank the Council for the privilege of attending meetings. Dr. Emil Stricker, Dr. Max Franklin and Dr. Andrew McCanse, members of the MSMA Advisory Council, have been a constant source of encouragement. We also thank Mr. Ray McIntyre, Executive Secretary, and the Staff at MSMA for their help and understanding. Miss Jean Duensing, managing editor, has been an inspiration in the production of these monthly articles.

No article would be complete or be recognized as mine without our usual plea. Doctors, please encourage your wives to join us so that "Together we can do more."

Remember, *"It is better to light one small candle than to curse the darkness."*

LETTERS to the Editor

To the Editor:

The continual morbid maligning of halothane has gone beyond scientific reasoning. Anecdotal reporting associating "hepatic toxicity" with halothane without adequate investigation and without scientific proof of such an entity has clogged the medical literature since the first reports in 1962 associating anesthesia in which halothane had been used with postoperative hepatic necrosis. The article, "Fluothane (Halothane) Anesthesia and Acute Hepatic Necrosis," reported in the October issue (1974) of Missouri Medicine falls in the same category.

At the present time and following more than ten years of extended investigation, halothane has not been shown to be an hepato-toxic agent. Neither has the latest incriminating factor of individual sensitivity or allergy been proven. Remember, even in layman's language, "associated with" is not synonymous with "due to"![1]

Where in this article are the preoperative liver function or enzyme studies or results of Australian antigen tests evidenced? Even the statistics from the National Halothane Study are misquoted. There were only nine cases of fatal postoperative hepatic necrosis out of 856,000 anesthetics and 10,171 necroscopies which were unexplainable, except to assign a possible etiologic association with the anesthetic agent. Seven of these patients had received halothane and four were repeated halothane anesthetics. In one large series in the National Halothane Study, cyclopropane was by far the most frequent anesthetic agent associated with postoperative fatal hepatic necrosis. However, fatal hepatic necrosis has occurred following virtually every type of anesthetic or combination of anesthetics in use today. The overall instance being too small to show a statistically significant difference between anesthetic agents or technique.[2]

Repeated anesthesia and surgery is associated with increased morbidity and mortality. Comparative figures in low risk, moderate risk or high risk patients who had received previous halothane anesthesia, as compared to those who had other anesthetic agents repeated, failed to incriminate halothane as being a more dangerous drug to repeat.[3]

The article under discussion quotes an incidence of massive hepatic necrosis of 7.1 per 10,000 patients following multiple exposure. No reference is given and such a figure is not tenable with any reliable statistical reports.

Policies adapted in anesthesia departments to not repeat halothane over a given period are set up (1) to protect the incrimination of a good agent or, all too often (2) for medical-legal reasons rather than scientific fact.

The anecdotal reporting in the article, like many others, lacks thorough investigation and diagnosis by exclusion cannot be made. Continual excessive verbiage of this nature adds only confusion to the medical literature.

Sincerely yours,
James D. Jones, II, M.D.
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New CDC Gonorrheal Therapy Recommendations

Missouri Medicine has received a copy of the latest treatment schedules for gonorrhea from the Center for Disease Control of the Public Health Service. It includes newly formulated recommendations for the treatment of gonococcal infections. They pertain to uncomplicated gonorrhea, treatment of sexual partners, gonorrhea in pregnancy, gonococcal and postgonococcal urethritis, acute salpingitis (PID), pharyngeal gonococcal infection, disseminated gonococcal infection and gonococcal infections in pediatric patients.

Because space does not permit publication of this material in the Journal, it is suggested that interested physicians obtain copies of these recommendations by requesting the report, "Gonorrhea—Recommended Treatment Schedules, 1974" from Technical Information Services, Bureau of State Services, Center for Disease Control, Dept. of HEW, Atlanta, Ga. 30333.

ANNOUNCING

BURDICK-MUNNS MEDICAL SUPPLY CO.

ELECTROCARDIOGRAPH TECHNICAL TRAINING PROGRAM

TOPEKA, KANSAS	**APRIL 4, 1975**	8:00 A.M.
KANSAS CITY, MISSOURI	**APRIL 11, 1975**	To
WICHITA, KANSAS	**APRIL 4, 1975**	
ST. LOUIS, MISSOURI	**APRIL 4, 1975**	5:00 P.M.

Please call Bud Lowe or Mike Warnstaff in Topeka, Kansas for your reservations

913-272-2300

A demonstration of Stress Monitoring will be included at the end of each day

MUNNS
MEDICAL
SUPPLY

County Society News

FIRST DISTRICT

COUNCILOR
JOHN N. MARTIN, ST. JOSEPH

Buchanan County Medical Society

Fifty-one St. Joseph and Northwest Missouri physicians attended the all-business meeting of the Buchanan County Medical Society. The event followed a dinner at the Hoof & Horn Steak House in St. Joseph on March 5.

Present for discussion and a question-and-answer session were Mr. Royal O. Cooper, Assistant Executive Secretary, MSMA; Mr. Don Wilson, Field Representative, MSMA; and Mr. Don Robert Watkins, project director of the Northwest Missouri PSRO in Kansas City.

Dr. William B. O'Connor presided at the meeting. Dr. John N. Martin, First District Councilor for the MSMA, served as moderator for the discussion and question-and-answer period.

Carl K. Ness, M.D., *Secretary*

Grand River Medical Society

The Grand River Medical Society held its second 1975 meeting on February 13 at the Chillicothe Country Club.

There were two speakers for the night. Dr. Burnell Landers of Research Hospital in Kansas City spoke on endoscopic procedures and, primarily, on gastric endoscopy and colonoscopy.

Dr. John Rose of Hedrick Medical Center in Chillicothe then presented slides on Xeroradiography and mammography.

Due to the lateness of the hour, a business meeting was not held.

Those in attendance from Chillicothe were Dr. and Mrs. Tom Cofer, Dr. and Mrs. Joseph Conrad, Dr. and Mrs. Leonard Fair, Dr. and Mrs. George Mandler, Dr. and Mrs. Dale Vandiver, Dr. Jim Yoon, Dr. and Mrs. John Rose and Dr. and Mrs. H. R. Trinidad.

Members from Carrollton were Dr. Warren Allen, Dr. John Platz and Dr. Bob Staton. Those from Brookfield were Dr. and Mrs. John Dixon and Dr. and Mrs. R. V. Bohnsack. Dr. and Mrs. Albert Cross of Trenton attended the meeting and Dr. Pat Galvez of Marceline and his guest from California, Dr. Leo Pet attended the meeting.

Hermanito R. Trinidad, M.D., *Secretary*

SECOND DISTRICT

COUNCILOR
LYSLE M. BACH, M.D., HANNIBAL

Chariton-Macon-Monroe-Randolph County Medical Society

The Chariton-Macon-Monroe-Randolph County Medical Society met in the Library Conference Room at Woodland Hospital in Moberly on February 16.

After reading the minutes of the previous meeting, the Secretary presented communications regarding the St. Louis Blue Shield voting board.

The program included discussion of the Missouri State Medical Association by Dr. James Cope, President, and Mr. Raymond McIntyre, Executive Secretary.

Dr. Cope discussed "Changes in the Medicare and Medicaid regulations regarding hospital certifications of patient, criteria for justification for admission." He then spoke about the AMA financial assessments and the possibility of a state group malpractice brokerage.

Mr. McIntyre discussed the upcoming MSMA Annual Session and resolutions pending before that meeting. He presented a report on the status of pending state Legislature bills that influence medical practice. A question-and answer period followed.

Members present were Drs. F. L. Harms, Salisbury; James Campbell and D. E. Eggleston, Macon; F. L. Barnett, Paris; Josephine Baker, R. O. Bautista, W. D. Chute, C. C. Cohrs, L. E. Huber, R. V. Tompson, G. R. Hudson and Robert Young, Moberly; and P. V. Dreyer, Huntsville.

Guests were Mrs. Harms, Mrs. Campbell, Mrs. Eggleston, Mrs. Barnett, Mrs. Bautista, Mrs. Chute, Mrs. Cohrs, Mrs. Tompson, Mrs. Young, Dr. Cope, Mr. and Mrs. McIntyre.

TENTH DISTRICT

COUNCILOR
EUGENE T. HANSBROUGH, M.D.,
POPLAR BLUFF

Butler-Ripley-Wayne-Carter County Medical Society

The Butler-Wayne-Ripley-Carter County Medical Society meeting, which was held on February

11, was called to order by Dr. Tom Wood, President. The minutes of the previous meeting were read and approved. The Treasurer's Report was given by Dr. Wood, who noted that about two thirds of the membership dues have been paid.

Dr. Wood discussed the unified membership proposal that is to come before the Missouri State Medical Association and read the proposed changes in the MSMA bylaws. The Society voted to support the proposal for unified membership plans and to instruct delegates to support this proposal at the MSMA Annual Session in April.

There was a discussion of the letter received from Blue Cross-Blue Shield which requests suggestions for candidates for the Board. Dr. Eugene T. Hansbrough, Tenth District Councilor, suggested that the Society attempt to support a member as a representative. The members voted to support Dr. Edwin K. Burford of Cape Girardeau as a candidate. Also, Dr. T. Eugene Ruff nominated Dr. George H. Ladyman of Poplar Bluff. His nomination was approved unanimously.

Dr. Hansbrough discussed honorary membership in the County Society for Dr. Fred L. Kneibert. This motion was approved and a letter will be sent to Mr. Ray McIntyre, MSMA Executive Secretary, proposing honorary membership in the MSMA and AMA for Dr. Kneibert.

After a lengthy discussion about the American Medical Association, it was expressed that the Society is moderately displeased with the economical status of the AMA, but that it does represent the Butler-Wayne-Ripley-Carter County Medical Society nationally and that members should do everything in their power to support the AMA. However, it was felt that there are a considerable number of areas that require some attention from the AMA delegates.

One of the areas includes problems about providing grass-root information to state and county medical societies with the hope of alleviating some of these problems and to allow the County Medical Society to have adequate input. The Society attempted to establish an educational facility to keep the members adequately informed.

Dr. Hansbrough was asked to present, as a regular part of each monthly meeting, a Council report on political and medical affairs that are prominent at the state and national levels. This involves a large number of politically oriented medical legislative bills before the state and national governments as well as bills and proposals before the AMA and MSMA. Dr. Hansbrough agreed to this function and members will attempt to comment on areas germane to the medical profession and forward opinions to the state and national organizations.

There also was discussion about certain facets of the AMA organization, especially in regard to the economical sphere. Professional journals were discussed at length. The members were asked to determine how many members of the Society feel that certain specialty journals and the publication, *Prism,* are of value. It was generally felt that the specialty journals are poorly accepted and do not serve the interest of the entire medical association. Dr. Barry B. White moved that the Society correspond with the AMA and instruct them about certain publications the members feel are an unnecessary expense to the organization and that some are poorly accepted, especially *Prism* as well as most of the professional specialty journals which were mentioned. The motion was seconded by Dr. S. T. Gernstetter, and the Secretary was instructed to write a letter to this effect to the office of the AMA. Also, it was moved to critically review all publications with the thought of reducing the number and frequency of publications as a means of conservation and economy.

Mr. J. Travis, sales representative of Merrill National Laboratories, presented a film on "Recurrent Urinary Tract Infections," an update for the 70s. The film was monitored by Dr. A. N. Reddy of the Society. An interesting round-table discussion followed the film showing.

The Society will continue to feature an educational program as a vital part of each monthly meeting. It was noted that this particular program, with the booklet, is accredited for three hours toward the Physician Recognition Award.

There was no further business. Dr. White moved for adjournment and Dr. Ruff seconded the motion. It was approved.

The next meeting will be held at the Hickory House in Poplar Bluff at 6:30 PM on March 11, 1975.

B. N. Till, M.D., *Secretary*

Mineral Area Medical Society

The Mineral Area Medical Society met in the Hoctor Building at Farmington State Hospital on February 27.

The scientific portion of the program consisted of a film, "Anaerobic Infections," which was presented by the Upjohn Company.

The business meeting was conducted by the President, Norma Farmer. The minutes of the previous meeting were summarized and approved.

The Credentials Committee reported that the applications of Drs. Kim, Wilson, Sernchief and Raksakulthai were in order and recommended that they be elected to membership in the society. Ballots were distributed and the four doctors were elected unanimously.

The 1975 Convention of the Missouri State Medical Association was discussed. The following delegates were elected: *St. Francois County,* Delegate, C. W. Chastain, M.D. and Alternate, R. A. Huckstep, M.D.; *Madison County,* Delegate, A. R. Rao, M.D. and Alternate, A. G. Karraker, M.D.; *Washington County,* Delegate, David Wilson, M.D. and Alternate, C. Borromeo, M.D.; *Iron County,* Delegate, Robert Dettmer, M.D. and Alternate, Marvin Menne, M.D.; *Reynolds County,* Delegate C. H. Appleberry, M.D. and Alternate, Jack Mullen, M.D.; *Bollinger County,* Delegate, Norma Farmer, M.D. and Alternate, Jay Tuttle, M.D. No resolutions were presented from this county. There was discussion about the proposed requirement that members of the Missouri State Medical Association would also be members of the American Medical Association. It was felt this issue should be left to the discretion of the delegates. It was felt that there was insufficient interest this year in having a hospitality room.

Dr. Chastain moved and Dr. Appleberry seconded that the Mineral Area Medical Society participate in the AMA membership recruitment program for 1975, with the Society to receive the refund of one half of the first year's AMA dues of all new members. Dr. Chastain will be in charge of this project.

On motion by Dr. R. C. Hoye and seconded by Dr. Borromeo, it was moved to endorse the establishment of a Community Cancer Council to be chaired by Dr. William Powers of St. Louis.

Dr. Jay Tuttle of Farmington was nominated for election to the Blue Shield Voting Board.

Discussion of the area CHP Agency for health planning was held, but no doctors were nominated to be representatives from this Society. Dr. Tuttle has worked with this agency and Dr. Chastain is active on the state level.

Dr. Chastain reported that the *St. Francois County Daily Journal* is interested in preparing a series of articles to be written by local physicians answering medical questions. It was felt that this would not represent an unethical activity and there was no objection to this project.

Dr. Chastain reported that plans are under way to arrange for a banquet with the members' wives in March, that there would be no meeting in April because of a conflict of dates with the Missouri

(Continued on page 207)

Pro-Banthīne®
brand of
propantheline bromide

Indications: Pro-Banthīne is effective as adjunctive therapy in the treatment of peptic ulcer. Dosage must be adjusted to the individual.

Contraindications: Glaucoma, obstructive disease of the gastrointestinal tract, obstructive uropathy, intestinal atony, toxic megacolon, hiatal hernia associated with reflux esophagitis, or unstable cardiovascular adjustment in acute hemorrhage.

Warnings: Patients with severe cardiac disease should be given this medication with caution. Fever and possibly heat stroke may occur due to anhidrosis.

Overdosage may cause a curare-like action, with loss of voluntary muscle control. For such patients prompt and continuing artificial respiration should be applied until the drug effect has been exhausted. Diarrhea in an ileostomy patient may indicate obstruction, and this possibility should be considered before administering Pro-Banthīne.

Precautions: Since varying degrees of urinary hesitancy may be evidenced by elderly males with prostatic hypertrophy, such patients should be advised to micturate at the time of taking the medication.

Overdosage should be avoided in patients severely ill with ulcerative colitis.

Adverse Reactions: Varying degrees of drying of salivary secretions may occur as well as mydriasis and blurred vision. In addition the following adverse reactions have been reported: nervousness, drowsiness, dizziness, insomnia, headache, loss of the sense of taste, nausea, vomiting, constipation, impotence and allergic dermatitis.

Dosage and Administration: The recommended daily dosage for adult oral therapy is one 15-mg. tablet with meals and two at bedtime. Subsequent adjustment to the patient's requirements and tolerance must be made.

How Supplied: Pro-Banthīne is supplied as tablets of 15 and 7.5 mg., as prolonged-acting tablets of 30 mg. and, for parenteral use, as serum-type vials of 30 mg.

SEARLE **Searle & Co.**
San Juan, Puerto Rico 00936

Address medical inquiries to: G. D. Searle & Co.
Medical Department, Box 5110, Chicago, Ill. 60680 481

"Antiacid" action for ulcer patients...

one of the many things you need in an anticholinergic.

Pro-Banthīne is considered adjunctive in total peptic ulcer therapy that may include diet, conventional antacids, bed rest, and other supportive measures.

Pro-Banthīne is provided in several different dosage forms which will meet virtually any clinical need. It is just as versatile in filling patient needs, among which are:

"Antiacid" action—Pro-Banthīne® (propantheline bromide) reduces gastric secretory volume and resting total and free acid.

"Analgesic" action—Pro-Banthīne helps to control the acid-spasm-pain complex.

Vigorous anticholinergic action—Pro-Banthīne® Vials, 30 mg., are for intramuscular or intravenous use when prompt and vigorous anticholinergic action is required.

Mild anticholinergic action—Pro-Banthīne® Half Strength, 7.5 mg. tablets, for more exact adjustment of maintenance dosage in mild to moderate gastrointestinal disorders.

Pro-Banthīne®
(propantheline bromide)

a good
option
in peptic
ulcer

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NO.4—for pain intensity below the need for injectables

As a rule, only pain that requires morphine is beyond the scope of Empirin® Compound with Codeine No. 4. That's because it delivers a full grain of codeine. (In the preferred phosphate form.) Its antitussive action is particularly appreciated by patients with fractured ribs, and following chest or abdominal surgery. Its low addiction liability is a bonus for all patients who require potent analgesia.

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Most other kinds of lesser pain respond to Empirin Compound with Codeine No. 3—whether musculoskeletal, neurological, soft-tissue or visceral. One might say No. 3 is an "all-purpose" analgesic — not too little, not too much. Just right for your out-patients in these categories.

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Wherever it hurts

EMPIRIN® COMPOUND c̄ CODEINE

No.3, codeine phosphate*(32.4 mg) gr ½ · No.4, codeine phosphate*(64.8 mg) gr 1

*Warning—may be habit-forming.

Each tablet also contains aspirin gr 3½, phenacetin gr 2½, caffeine gr ½.

Before prescribing, see complete prescribing information in SK&F literature or *PDR*. The following is a brief summary.

Indications: Edema associated with congestive heart failure, cirrhosis of the liver, the nephrotic syndrome; steroid-induced and idiopathic edema; edema resistant to other diuretic therapy. Also, mild to moderate hypertension.

Contraindications: Pre-existing elevated serum potassium. Hypersensitivity to either component. Continued use in progressive renal or hepatic dysfunction or developing hyperkalemia.

Warnings: Do not use dietary potassium supplements or potassium salts unless hypokalemia develops or dietary potassium intake is markedly impaired. Enteric-coated potassium salts may cause small bowel stenosis with or without ulceration. Hyperkalemia (>5.4 mEq/L) has been reported in 4% of patients under 60 years, in 12% of patients over 60 years, and in less than 8% of patients overall. Rarely, cases have been associated with cardiac irregularities. Accordingly, check serum potassium during therapy, particularly in patients with suspected or confirmed renal insufficiency (e.g., elderly or diabetics). If hyperkalemia develops, substitute a thiazide alone. If spironolactone is used concomitantly with 'Dyazide', check serum potassium frequently—both can cause potassium retention and sometimes hyperkalemia. Two deaths have been reported in patients on such combined therapy (in one, recommended dosage was exceeded; in the other, serum electrolytes were not properly monitored). Observe patients on 'Dyazide' regularly for possible blood dyscrasias, liver damage or other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving Dyrenium (triamterene, SK&F). Rarely, leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with the thiazides. Watch for signs of impending coma in acutely ill cirrhotics. Thiazides are reported to cross the placental barrier and appear in breast milk. This may result in fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly other adverse reactions that have occurred in the adult. When used during pregnancy or in women who might bear children, weigh potential benefits against possible hazards to fetus.

Precautions: Do periodic serum electrolyte and BUN determinations. Do periodic hematologic studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in postsympathectomy patients. The following may occur: hyperuricemia and gout, reversible nitrogen retention, decreasing alkali reserve with possible metabolic acidosis, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), digitalis intoxication (in hypokalemia). Use cautiously in surgical patients. Concomitant use with antihypertensive agents may result in an additive hypotensive effect.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis; rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting (may indicate electrolyte imbalance), diarrhea, constipation, other gastrointestinal disturbances. Rarely, necrotizing vasculitis, paresthesias, icterus, pancreatitis, and xanthopsia have occurred with thiazides alone.

Supplied: Bottles of 100 capsules; in Single Unit Packages of 100 (intended for institutional use only).

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KEEP THE HYPERTENSIVE PATIENT ON THERAPY KEEP THERAPY SIMPLE WITH

DYAZIDE®

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Each capsule contains 50 mg. of Dyrenium® (brand of triamterene) and 25 mg. of hydrochlorothiazide.

Neither inconvenient potassium supplements nor special K^+ rich diets needed as a rule. Just 'Dyazide' once or twice daily for maintenance.

20
40
60
80
100
120
140
160
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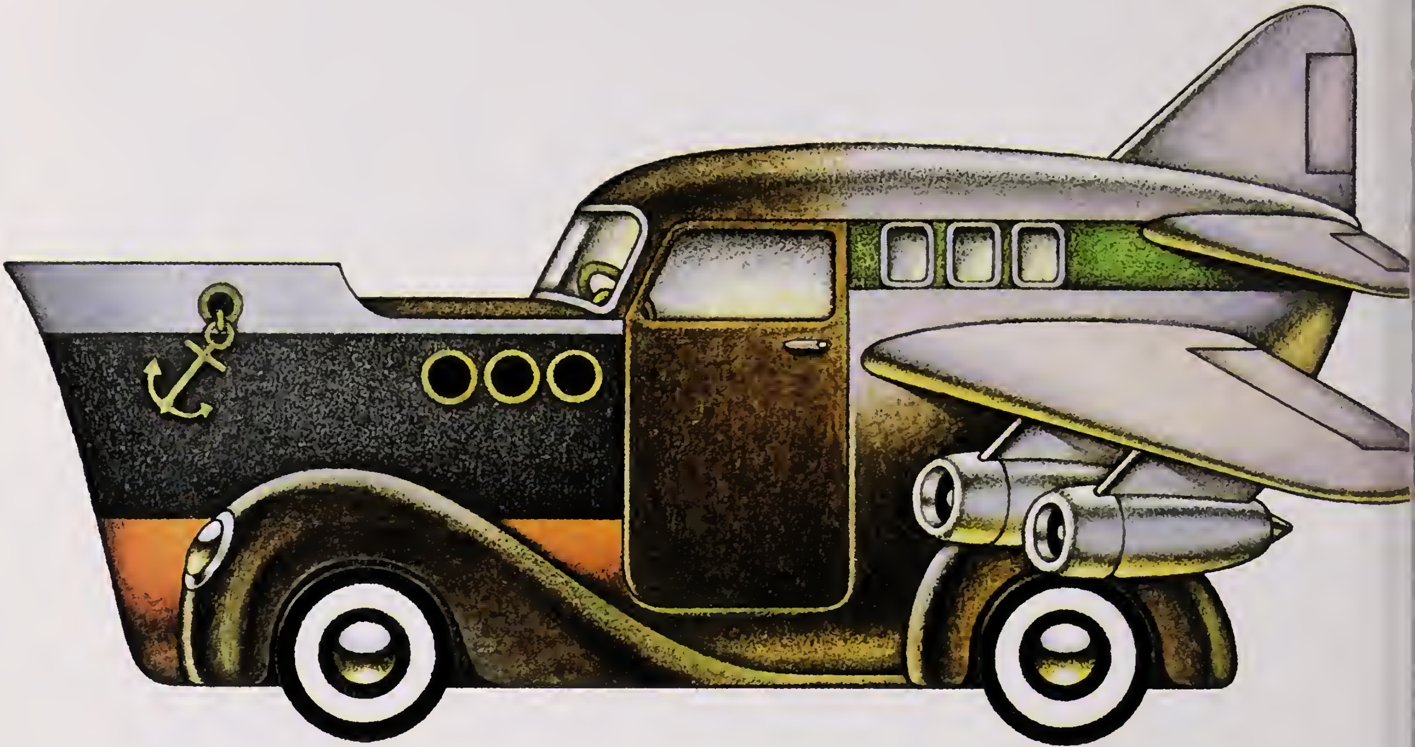
200
220
240
260
280
300

Two prime reasons patients drop out of hypertensive therapy are (1) the patient failed to understand directions, and (2) the regimen was overly complicated. Dosage is simple with 'Dyazide', easily understood, once or twice daily, depending on response. There's no need to complicate the regimen with potassium supplements or unwieldy potassium-rich diets.

TO KEEP BLOOD PRESSURE DOWN AND KEEP POTASSIUM LEVELS UP



On land, sea, and in the air...

Up to 24 hours of effective control with a single dose...in nausea, vomiting and dizziness associated with motion sickness.

Dosage: 25 to 50 mg. 1 hour before travel.

Available on prescription only.

BRIEF SUMMARY OF PRESCRIBING INFORMATION

CONTRAINDICATIONS. Administration of Antivert during pregnancy or to women who may become pregnant is contraindicated in view of the teratogenic effect of the drug in rats.

The administration of meclizine to pregnant rats during the 12-15 day of gestation has produced cleft palate in the offspring. Limited studies using doses of over 100 mg./kg./day in rabbits and 10 mg./kg./day in pigs and monkeys did not show cleft palate. Congeners of meclizine have caused cleft palate in species other than the rat.

Meclizine HCl is contraindicated in individuals who have shown a previous hypersensitivity to it.

WARNINGS. Since drowsiness may, on occasion, occur with use of this drug, patients should be warned of this possibility and cautioned against driving a car or operating dangerous machinery.

Usage in Children: Clinical studies establishing safety and effectiveness in children have not been done; therefore, usage is not recommended in the pediatric age group.

Usage in Pregnancy: See "Contraindications."

ADVERSE REACTIONS. Drowsiness, dry mouth and, on rare occasions, blurred vision have been reported.

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A division of Pfizer Pharmaceuticals
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Antivert®/25 Chewable Tablets
(meclizine HCl) 25 mg.
for motion sickness

;ounty Society News (Cont'd)

tate Medical Association and that an outstanding rogram in Nephrology is being prepared for the lay meeting. It was the consensus of opinion that ɔ meetings be held during the summer months.

George L. Watkins, M.D., formerly of Farmingɒn, having moved to California, was voted to inctive status.

Dr. Farmer reported on numerous issues pending ı the Missouri Legislature. Members were urged) contact their legislators about specific bills of inrest. There was prolonged discussion about Senate ill # 300 to establish mental health districts in the ate and to provide for the awarding of state funds) these mental health districts for distribution among various independent mental health practitioners and clinics. On motion of Dr. Appleberry, seconded by Dr. Tuttle, the Society voted unanimously to contact the representatives and senators from the area in opposition to this bill.

Dr. Mullen reported that an Extension Club in the county was publicized recently as arranging a series of free immunization clinics at which the shots were given by some volunteer nurses. He wondered if this project had been endorsed by the County Medical Society and if anyone in the Society knew anything about the medical supervision for the project. No one present was aware of any of the details of this program.

There being no further business, the program was adjourned at 9:30 PM.

C. W. CHASTAIN, M.D., *Secretary*

Socioeconomic Congress to Focus on National Health Insurance

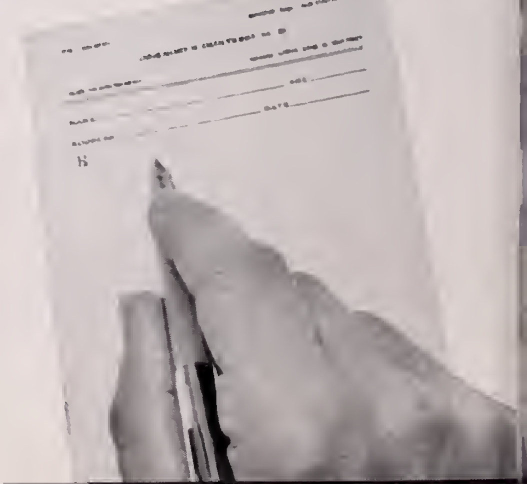
The impact of National Health Insurance on health care delivery and the mechanics of an NHI program will be subjects for consideration at the Ninth National Socioeconomic Congress to be held on April 25-26 at the Regency Hyatt House in Atlanta, Ga. The Congress is sponsored by the AMA Council on Medical Service and the Medical Association of Georgia. The registration fee is $50. Send registrations to Ninth Socioeconomic Congress, c/o Division of Medical Practice, AMA, 535 N. Dearborn St., Chicago, Ill. 60610.

Continuing Education Coming Events

(Continued from page 197)

May 29	**Conference: The Risk of Cytomegalovirus Infection Transmitted by Blood Transfusion** Community Blood Center of Greater Kansas City Plaza Inn, Kansas City
June 4	**Seminar: Acute and Chronic Respiratory Failure** Ed Bixby Institute for Postgraduate Medical Education Research Hospital and Medical Center, Kansas City
June 5-7	**Symposium: Clinical Care** M.U. Kansas City School of Medicine Crown Center Hotel, Kansas City
June 6-7	**Eighth Annual Professional Meeting** Missouri Chapter, American College of Surgeons Sheraton-West Port Inn, St. Louis
June 21	**Semiannual Professional Program: Recent Advances in Medical Oncology** Ellis Fischel State Cancer Hospital and Cancer Research Center Ramada Inn, Columbia

Bioequivalenc



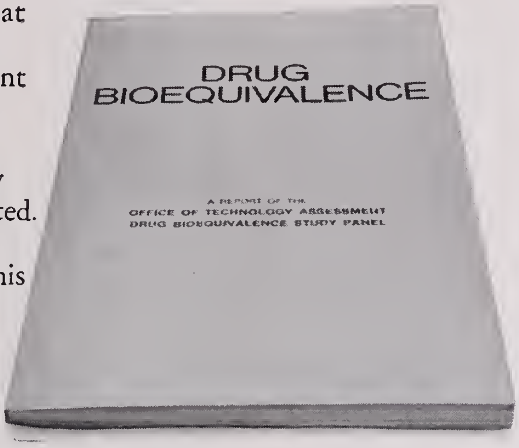
the weight of scientific opinion:

If the pharmacist substituted a chemically equivalent drug for the one you have specified for your patient—could you be certain of that product's safety and effectiveness simply because the chemical content was the same?

Definitely not, unless bioequivalence tests and other quality assurance checks had been conducted. The pharmaceutical industry and many scientists have maintained this position for years, but others have questioned it. Now the Office of Technology Assessment of the Congress of the United States has eported on the issue in its Drug Bioequivalence Study.*

Here are a few definitive statements in the O.T.A. report:

"...the problem of bioinequivaency in chemically equivalent products is a real one. Since the studies in which lack of bioequivalence was demonstrated involved marketed products that met current compendial standards, these documented intances constitute unequivocal evidence that neither the present standards for testing the finished product nor the specifications for materials, manufacturing process, and controls are adequate to ensure that ostensibly equivalent drug products are, in fact, equivalent in bioavailability.


DRUG
BIOEQUIVALENCE
A REPORT OF THE
OFFICE OF TECHNOLOGY ASSESSMENT
DRUG BIOEQUIVALENCE STUDY PANEL

"While these therapeutic failures resulting from problems of bioavailability were recognized and well documented, it is entirely possible that other therapeutic failures and/or instances of toxicity that had a similar basis have escaped attention."

The Pharmaceutical Manufacturers Association supports federal legislative amendments that would require manufacturers of duplicate prescription pharmaceutical products, subject to new drug procedures, to document:

(a) chemical equivalence; and (b) biological equivalence, where bioavailability test methods have been validated as a reliable means of assuring clinical equivalence; or (c) where such validation is not possible, therapeutic equivalence.

In addition, the PMA supports federal legislation that would require certification of all manufacturers of prescription products before they could start in business, annual inspections and certification thereafter, and strict adherence to FDA regulations on good manufacturing practices.

The overall quality of the United States drug supply is excellent. But only a total quality assurance program, envisaged in these and other policy positions adopted by the PMA Board of Directors in 1974, can bring about acceptable levels of performance by all prescription drug manufacturers and thereby assure the integrity of your prescription...

P·M·A

Pharmaceutical Manufacturers
Association
1155 Fifteenth Street, N.W.
Washington, D.C. 20005

*Copies of the complete report on Drug Bioequivalence may be obtained from the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402.

protecting the integrity of your prescription

New Members

Donald J. Allcorn, M.D., 807 Stadium, Columbia, has become a member of Boone County Medical Society. Dr. Allcorn received his M.D. degree at the University of Missouri in 1966. He is in general practice.

Aurora I. Arribas, M.D., 215 S. Sibley, Buckner, has become a member of Jackson County Medical Society. Dr. Arribas is a native of the Philippines, received her preliminary education at Far Eastern University and her M.D. degree at Far Eastern University in 1967. She is in family practice.

Gilulio J. Barbero, M.D., 807 Stadium, Columbia, has become a member of Boone County Medical Society. Dr. Barbaro is a native of Mt. Vernon, received his preliminary education at the University of Maine and his M.D. degree at the University of Pennsylvania in 1947. He specializes in pediatrics.

Robert W. Barton, M.D., 4910 Forest Park, St. Louis, has become a member of St. Louis County Medical Society. Dr. Barton is a native of Ann Arbor, Mich., received his preliminary education at the University of Chicago and his M.D. degree at the University of Chicago in 1967. He specializes in internal medicine.

Eugene A. Bauer, M.D., Barnes Hospital Plaza, St. Louis, has become a member of St. Louis Medical Society. Dr. Bauer is a native of Illinois, received his preliminary education at Northwestern University and his M.D. degree at Northwestern University in 1967. He specializes in dermatology.

Gaetano Bazzano, M.D., 34 Washington Terr., St. Louis, has become a member of St. Louis Medical Society. Dr. Bazzano is a native of Italy, received his preliminary education at the Lyceum-Gymnasium and his M.D. degree at the University of Rome in 1956. He specializes in internal medicine.

Victor D. Bentinganan, M.D., 703 W. Main, Fredericktown, has become a member of Mineral Area County Medical Society. Dr. Bentinganan is a native of the Philippines, received his preliminary education at the University of the Philippines and his M.D. degree at the University of Santo Tomas in 1960. He is in general practice.

Olga M. Blair, M.D., 1402 S. Grand, St. Louis, has become a member of St. Louis Medical Society. Dr. Blair is a native of Cuba, received her preliminary education at the Institute of Second Education and her M.D. degree at Havana University in 1959. She specializes in pathology.

Richard A. Blath, M.D., Barnes Hospital Plaza, St. Louis, has become a member of St. Louis Medical Society. Dr. Blath is a native of St. Louis, received his preliminary education at Miami University and his M.D. degree at Washington University in 1971. He is a resident in urology.

Robert M. Bruce, M.D., 4550 Scott, St. Louis, has become a member of St. Louis Medical Society. Dr. Bruce is a native of St. Louis, received his preliminary education at the University of Minnesota and his M.D. degree at the University of Minnesota in 1968. He specializes in internal medicine.

Bruce W. Burleigh, M.D., 2700 McClelland Blvd., Joplin, has become a member of Jasper County Medical Society. Dr. Burleigh is a native of Yonkers, N. Y., received his preliminary education at Tufts University and his M.D. degree at Yale University in 1969. He specializes in orthopedic surgery.

Lawrence Chang, M.D., 6651 Chippewa, St. Louis, has become a member of St. Louis Medical Society. Dr. Chang is a native of China, received his preliminary education at Hautes Etudes and his M.D. degree at Cheeloo University in 1940. He specializes in psychiatry.

James L. Chapel, M.D., 807 Stadium, Columbia, has become a member of Boone County Medical Society. Dr. Chapel is a native of Ontario, Canada, received his preliminary education at the University of Toronto and his M.D. degree at the University of Toronto in 1954. He specializes in child psychiatry.

George D. Comfort, M.D., 1415 S. Morris, Mexico, has become a member of Audrain County Medical Society. Dr. Comfort is a native of Columbia, received his preliminary education at the University of Missouri in 1965. He is in family practice.

M. Fredrica Godshalk, M.D., 807 Stadium, Columbia, has become a member of Boone County Medical Society. Dr. Godshalk is a native of Washington, D. C., received her preliminary education at Hood College and her M.D. degree at the University of Maryland in 1969. She specializes in anesthesiology.

Bruce J. Gordon, M.D., 807 Stadium, Columbia, has become a member of Boone County Medical

Society. Dr. Gordon is a native of Chicago, Ill., received his preliminary education at Northwestern University and his M.D. degree at Northwestern University in 1969. He specializes in anesthesiology.

Rodolfo T. Guillen, M.D., 2821 N. Ballas, St. Louis, has become a member of St. Louis County Medical Society. Dr. Guillen is a native of the Philippines, received his preliminary education at the University of the Philippines and his M.D. degree at Far Eastern University in 1957. He specializes in internal medicine.

M. R. Hayden, M.D., Camdenton Medical Center, Camdenton, has become a member of Mid-Missouri County Medical Society. Dr. Hayden is a native of Sandpoint, Idaho, received his preliminary education at the University of Missouri and his M.D. degree at the University of Missouri in 1970. He is in family practice.

Savitri Jain, M.D., 1515 Lafayette, St. Louis, has become a member of St. Louis County Medical Society. Dr. Jain is a native of New Delhi, India, received her preliminary education at the Hindu College and her M.D. degree at Lady Hardinge College in 1958. She specializes in internal medicine.

W. Kuyakanon, M.D., 216 S. Kingshighway, St. Louis, has become a member of St. Louis Medical Society. Dr. Kuyakanon is a native of Thailand, received his preliminary education at Bangkok, Thailand and his M.D. degree at Chiang Mai in 1970. He specializes in obstetrics and gynecology.

John R. McCormick, M.D., 216 S. Kingshighway, St. Louis, has become a member of St. Louis Medical Society. Dr. McCormick is a native of California, received his preliminary education at the University of Southern California and his M.D. degree at Boston University in 1965. He specializes in thoracic and cardiovascular surgery.

John Mantovani, Jr., M.D., 10303 Sannois, St. Louis, has become a member of St. Louis Medical Society. Dr. Mantovani is a native of St. Louis, received his preliminary education at the University of Evansville and his M.D. degree at the University of Missouri in 1974. He specializes in pediatrics.

John P. Murrray, M.D., 3108 Queeny Towers, Barnes Hospital Plaza, St. Louis has become a member of St. Louis Medical Society. Dr. Murray is a native of West Virginia, received his preliminary education at Vanderbuilt University and his M.D. degree at Washington University in 1966. He specializes in otolaryngology.

Nora R. Paculdo, M.D., 3400 Frederick, St. Joseph, has become a member of Buchanan County Medical Society. Dr. Paculdo is a native of the Philippines, received her preliminary education at the University of Santo Tomas and her M.D. degree at the University of Santo Tomas in 1957. She specializes in child psychiatry.

Lee I. Pickering, M.D., 1515 W. Truman Rd., Independence, has become a member of Jackson County Medical Society. Dr. Pickering is a native of Independence, received his preliminary education at Park College and his M.D. degree at the University of Missouri in 1967. He specializes in internal medicine.

K. Craig Place, M.D., St. Luke's Hospital, Kansas City, has become a member of Jackson County Medical Society. Dr. Place is a native of Aurora, Ill., received his preliminary education at the University of Illinois and his M.D. degree at the University of Kansas in 1973. He specializes in general surgery.

Michael J. Porter, M.D., 751 E. 63rd, Kansas City, has become a member of Jackson County Medical Society. Dr. Porter is a native of New York, N. Y., received his preliminary education at Washington University and his M.D. degree at the University of Missouri in 1970. He specializes in anesthesiology.

V. Raksakulthai, M.D., 703 W. Main, Fredericktown, has become a member of Mineral Area County Medical Society. Dr. Raksakulthai is a native of Thailand, received his preliminary education at the Faculty of Medical Sciences and his M.D. degree at Chiengmai Medical School in 1966. He specializes in obstetrics and gynecology.

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Thomas E. Reh, M.D., 6420 Clayton Rd., St. Louis, has become a member of St. Louis Medical Society. Dr. Reh is a native of St. Louis, received his preliminary education at St. Louis University and his M.D. degree at St. Louis University in 1969. He specializes in radiology.

Jerry A. Royer, M.D., 807 Stadium, Columbia, has become a member of Boone County Medical Society. Dr. Royer is a native of Troy, Ohio, received his preliminary education at Manchester College and his M.D. degree at Indiana University in 1969. He is in family practice.

Salma Saifee, M.D., 4911 Barnes Hospital Plaza, St. Louis, has become a member of St. Louis Medical Society. Dr. Saifee is a native of Pakistan, received his preliminary education at Nazareth College and his M.D. degree at Liaquat College in 1961. He specializes in obstetrics and gynecology.

Antonio Simonian, M.D., 401 River Bluff, St. Charles, has become a member of St. Louis Medical Society. Dr. Simonian received his M.D. degree from the Facultad de Medicina in Spain in 1968. He is in industrial and occupational medicine.

Robert J. Snowe, M.D., 1718 S. Ingram, Sedalia, has become a member of Pettis County Medical Society. Dr. Snowe is a native of New York, N. Y., received his preliminary education at New York University and his M.D. degree at the State University of New York in 1964. He specializes in pediatrics.

Thomas L. Stern, M.D., 1740 W. 92nd, Kansas City, has become a member of Jackson County Medical Society. Dr. Stern is a native of San Francisco, Calif., received his preliminary education at Williamette University and his M.D. degree at the University of Oregon in 1950. He is in family practice.

Frank W. Titterington, M.D., 44th and Wornall Rd., Kansas City, has become a member of Jackson County Medical Society. Dr. Titterington is a native of Kansas City, received his preliminary education at the University of Missouri-Kansas City and his M.D. degree at the University of Missouri-Columbia in 1972. He specializes in internal medicine.

David E. Wilson, M.D., Austin Plaza, Potosi, has become a member of Mineral Area County Medical Society. Dr. Wilson is a native of Kansas City, received his preliminary education at Union College and his M.D. degree at Loma Linda University in 1969. He is in general practice.

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Missouri Medicine in Review

FORTY YEARS AGO

Charles D. Humberd, M.D., President of Nodaway County Medical Society, writes the following:

"A country doctor has recently proved his efficiency and merited a worldwide acclaim by bringing a whole set of premature quintuplets safely through perilous days into a normal babyhood. His stupendous feat makes the following quotation of current interest, since this record seems to have escaped notice in medical literature. Aulus Gellius wrote his 'Noctes Atticae' (Attic Nights) 18 centuries ago. Book X, Chapter 2 read, in translation, something like this:

" 'The philosopher Aristotle has recorded that an Egyptian woman produced five children at one birth, the utmost limit, as he said, of human parturition, nor was it ever known that more than this number were born together, and this number, he says, is very unusual. But in the time of Augustus, the historians of those times relate a female servant of Caesar Augustus, in the province of Laurentum, brought forth five children. They lived a few days, and the mother died not long after she had delivered. A monument of the fact was erected by the command of Augustus in the road leading to Laurentum, and the number of children she produced, which we have mentioned, was inscribed on it.' "

TWENTY-FIVE YEARS AGO

"Four score and" 20 years ago, a group of physicians formed the Missouri State Medical Association. At the 1950 Annual Session, members of the MSMA will celebrate the culmination of 100 years of organized medicine in Missouri. The session will be held at Hotel Jefferson in St. Louis on March 26-29. Color television, thought by many to be a historic forward step in the teaching of medicine, will be used for the first time in a program of th Association and, also, it will be the first time to b shown in this section of the country. This enable a large group to have the same view of an operatio or an examination that usually is possible for onl a few.

An appropriately bound copy of the *History o the Missouri State Medical Association,* written b Robert E. Schlueter, M.D. of St. Louis, will b given to members at the Annual Banquet in hono of past-presidents. The history will be publishe in the Journal, but the anniversary volume will b distributed only at the banquet.

Brig. Gen. Wallace H. Graham, Washingto D. C., has been appointed Special Assistant o Medical Reserve Affairs to Maj. Gen. Harry G Armstrong, Air Surgeon General.

TEN YEARS AGO

The Annual Banquet and Installation of Officer of the Greene County Medical Society was held o February 3 in Ozark. This year's dinner-dance in cluded as a special feature entertainment by th "Greene County Boys," who recently returned fro New York where they were featured on the "I'v Got A Secret" television show.

Dr. H. Waldo Bird assumed new duties as pro fessor of psychiatry and associate dean of the S Louis University School of Medicine on January 1 Dr. Bird came from the University of Michiga where he was associate professor of psychiatry an former assistant dean.

Dr. John W. Josse has been appointed professo and head of the Department of Physiology at Was ington University School of Medicine. The appoin ment will become effective on July 1, 1965. D Josse has been associated with the School of Med icine since July, 1963. He will succeed Dr. Harve L. White, emeritus professor of physiology, wh has been head of the department since 1948. D Josse previously was a research fellow working i association with Nobel Prize winner Arthur Kor berg both at Washington University and Stanfor University, where he did chemical and statistic analysis of the structure of DNA. During the pa year and a half, Dr. Josse has isolated the en zyme pyrophosphatase from bacteria and crysta lized the protein.

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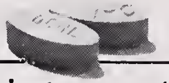

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Chronic urinary tract infections (primarily pyelonephritis, pyelitis and cystitis) due to susceptible organisms (usually *E. coli, Klebsiella-Enterobacter, Proteus mirabilis,* and, less frequently, indole-positive proteus species).

Note: The increasing frequency of resistant organisms limits the usefulness of antibacterials, especially in chronic and recurrent urinary tract infections.

Contraindications: Hypersensitivity to trimethoprim or sulfonamides; pregnancy; nursing mothers.

Warnings: Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia in elderly patients on diuretics, primarily thiazides. Sore throat, fever, pallor or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted. Data are insufficient to recommend use in infants and children under 12.

Precautions: Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, allergy or bronchial asthma; and in those with glucose-6-phosphate dehydrogenase deficiency, where hemolysis may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function.

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Usual adult dosage: Two tablets b.i.d. for 10 to 14 days.
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15-30	2 tablets every 24 hours
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118th MSMA Annual Session
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Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

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and/or severity of grand mal seizu
require increased dosage of stand
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age, weigh potential benefit
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s severely depressed, or with latent
sion, or with suicidal tendencies.
Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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better able to care for himself, less confused in his thinking; more sociable and less troubled by dizzy spells and depressed moods. ...no great accomplishment for most people, but a modest improvement that can be a significant advance for many elderly patients.

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Hydergine®

SUBLINGUAL TABLETS containing dihydroergocornine 0.167 mg, dihydroergocristine 0.167 mg, and dihydroergokryptine 0.167 mg, as the mesylates, representing a total of 0.5 mg Hydergine.

2 sublingual tablets
three times a day.

Contraindications: Hypersensitivity to the drug.
Precautions: *Because the target symptoms are of unknown etiology, careful diagnosis should be attempted before prescribing Hydergine.*
Adverse Reactions: Serious side effects have not been found. Some sublingual irritation, transient nausea, and gastric disturbances have been reported. Hydergine does not possess the vasoconstrictor properties of natural ergot alkaloids.
Dosage and Administration: Two sublingual tablets three times daily. Alleviation of symptoms is usually gradual and results may not be observed for 3-4 weeks.

75-359

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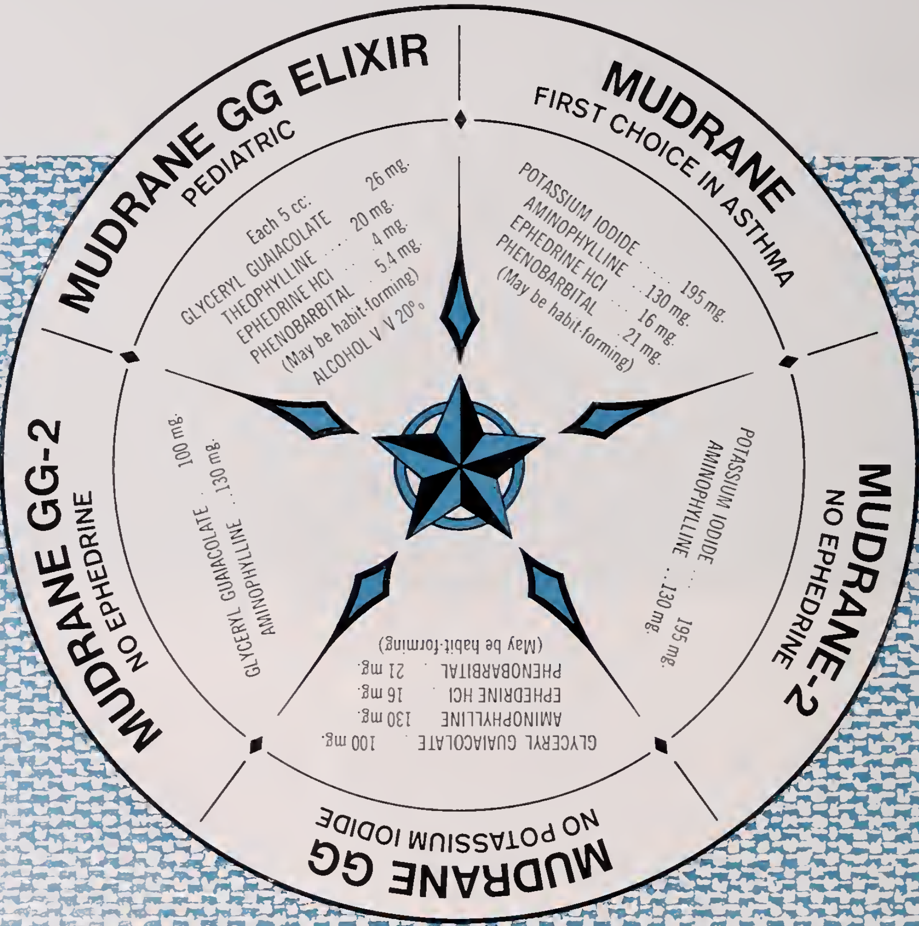
Discreet formulations of four well regarded drugs for the relief of bronchial distress—Potassium Iodide, Glyceryl Guaiacolate, Aminophylline, Ephedrine with Phenobarbital (to lessen cardiac stimulation).



MUDRANE
FIRST CHOICE IN ASTHMA
POTASSIUM IODIDE ..... 195 mg.
AMINOPHYLLINE ..... 130 mg.
EPHEDRINE HCl ..... 16 mg.
PHENOBARBITAL ..... 21 mg.
(May be habit-forming)

MUDRANE-2
NO EPHEDRINE
POTASSIUM IODIDE ..... 195 mg.
AMINOPHYLLINE ..... 130 mg.

MUDRANE GG
NO POTASSIUM IODIDE
GLYCERYL GUAIACOLATE ..... 100 mg.
AMINOPHYLLINE ..... 130 mg.
EPHEDRINE HCl ..... 16 mg.
PHENOBARBITAL ..... 21 mg.
(May be habit-forming)

MUDRANE GG-2
NO EPHEDRINE
GLYCERYL GUAIACOLATE ..... 100 mg.
AMINOPHYLLINE ..... 130 mg.

MUDRANE GG ELIXIR
PEDIATRIC
Each 5 cc:
GLYCERYL GUAIACOLATE ..... 26 mg.
THEOPHYLLINE ..... 20 mg.
EPHEDRINE HCl ..... 4 mg.
PHENOBARBITAL ..... 5.4 mg.
(May be habit-forming)
ALCOHOL V V 20%

INDICATIONS: For the prompt symptomatic relief of bronchial asthma, emphysema and bronchiectasis. The Mudranes dilate the bronchi and liquefy mucus plugs. DOSAGE: Tablet; One tablet with a full glass of water 3 or 4 times daily as required. Divide tablet for child's dose. Elixir; Children, 1 cc for each 10 lbs. of body weight. May be repeated 3 or 4 times a day. Adult, one tablespoonful 4 times daily. All doses should be followed with a glass of water.

CONTRAINDICATIONS: Aminophylline/Theophylline is contraindicated in the presence of severe cardiac arrhythmias and patients with massive myocardial damage. Ephedrine, in presence of severe heart disease, extreme hypertension, and in hyperthyroidism. Phenobarbital, in porphyria and in patients with known phenobarbital sensitivity. Potassium Iodide, in pregnancy (to protect the fetus against possible iodine-induced depression of thyroid activity), in tuberculosis (produces gumma dissolution), and in acne; also in the presence of known iodide sensitivity. PRECAUTIONS: Aminophylline/Theophylline should be avoided in patients with massive myocardial damage and/or severe cardiac arrhythmias. In children, overdose may cause vomiting, cardiac arrhythmias, and severe agitation. Ephedrine should be used with caution in the presence of severe cardiac disease, particularly arrhythmias and angina pectoris; avoid in hyperthyroidism and severe hypertension. Phenobarbital may be habit-forming. Avoid overdosage. Potassium Iodide: Discontinue in the presence of skin rash, swelling of the eyelids and severe frontal headache. Long use may cause goiter. ADVERSE REACTIONS: Aminophylline/Theophylline may cause nausea, cardiac arrhythmias, and aggravate severe myocardial disease. It may cause headaches and tachycardia. Vomiting and dizziness are not uncommon. Ephedrine: In patients hypersensitive to CNS stimulation, ephedrine may cause nervousness, tachycardia, extrasystole and ventricular arrhythmias. May cause urinary retention, especially in the presence of partial prostatic obstruction. Psychoneurosis may be aggravated. Pre-existing anginal pain will be aggravated. Phenobarbital may produce severe skin rash. Avoid overdosage. May be habit-forming. Potassium Iodide may cause nausea. Over very long period of use, iodides cause goiter. Discontinue if patient develops skin rash, eye irritation, eyelid swelling, or severe frontal headache.

HOW SUPPLIED: Mudrane and Mudrane GG available in bottles of 100 and 1000 tablets; Mudrane-2 and Mudrane GG-2 in 100s; Elixir in pints and half-gallons.

Federal law prohibits dispensing without prescription.

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MSMA

NEWS

ROUND - UP

MAY, 1975

Malpractice dominates Annual Session

The Missouri State Medical Association's newly-formed pro-ssional liability insurance company (MSMI, Inc.) proved to the headline attraction during the 117th Annual Session, pril 17-20, in St. Louis.

The company's structure was explained before a Reference ommittee and the House of Delegates later received the in-rmation. Also, representatives of Rollins Burdick Hunter, e broker for MSMI, were on hand to discuss individual licies with physicians.

The issue which drew the most floor debate during the Ses-on was a proposed resolution which would have established Unified Membership" with the AMA. Under the proposal, a ysician would have had to join the AMA in order to be a SMA member.

Although the issue received a favorable 92-64 vote, it failed gain the two-thirds majority it required for passage.

The resolution was reconsidered during Friday's meeting of e House, but again failed to pass.

In all, the House adopted 25 of the 38 resolutions presented Delegates. Following is a brief summary of some of the solutions which were adopted:

GOVERNMENTAL

Invasion of Patient Privacy — Directs the MSMA and AMA continue to work for and support full confidentiality in pa-ent record information.

Patients' SSA Eligibility Status — Resolves that the MSMA nd AMA petition the Social Security Administration to ovide eligibility data on all recipients by numbered phone or tter upon request whenever an eligible recipient applies for rvice.

Politics in V.A. Hospitals — States that since the PSRO law lieves the legislative branch of government from any utiliza-on review in public and private hospitals by placing the sponsibility with the Department of HEW, all requests by atients and veterans' representatives be sent directly to EW without benefit of a personal letter from a legislator. his will be introduced in AMA House of Delegates.

PSRO in Government Hospitals — Directs Missouri delega-on to introduce in the AMA House a resolution which de-cribes PSRO as a cost containment measure for medical ser-ices. Calls for the Federal government to (1) apply PSRO to overnment-owned and controlled hospitals and extended care acilities in Missouri for a period of 2 years; and (2) provide a eport to the citizens of Missouri at the end of two years as to he benefits derived and problems encountered.

PSRO — Resolves that the Department of HEW be advised hat the intent of the PSRO Law is being subverted because EW is promulgating regulations which should be the work of cal PSRO's. Adds that if PSRO is not returned to the local vel, the MSMA will (1) promote non-participation in PSRO; 2) institute legal actions and, if these are unsuccessful; (3) ork for repeal of the law.

Dr. Max S. Franklin
MSMA President-Elect

Dr. R. Allen Chandler
MSMA President

PSRO Progress Report — Instructs MSMA and AMA to provide members a progress report on the accomplishments of the PSRO Advisory Committee, the $1 million HEW grant to AMA for specialty society "criteria," and a description of the AMA's amendments to the PSRO Law.

PHYSICIAN AFFAIRS

Component Medical Societies — Directs the MSMA President to appoint an Ad Hoc Committee to study the feasibility of a meeting of representatives of the component medical societies and proceed with the meeting if so indicated.

Hospital Discharge Data — The House agreed in principal with a resolution protesting the Missouri Hospital Record Abstract Sheet as distributed by the Division of Health. Stated that all interested parties should work together for an acceptable report form.

Individual Practice Associations — Instructs MSMA to look into the development of individual practice as a possible alternative to HMO's.

Continued on Back Page

Chiropractic bill passes House, contact urged

Many chiropractors across the state are probably quite pleased today after winning their first battle (not the war!!) in the Missouri General Assembly in many, many years.

Only 500 strong, the chiropractors launched a concentrated effort of personal contact to gain House passage of HB 342 (Extension of Chriopractic). This bill, if enacted by the Missouri Senate, would allow chiropractors to use "heat, cold water, sound and electricity" in treating patients. In other words . . . they could practice *physical therapy!*

Dr. John I. Matthews, MSMA Legislative Committee Chairman, is urging all MSMA members to CONTACT their STATE SENATOR and express their OPPOSITION to HB 342. If you need the name of your Senator or information on the bill, contact MSMA Headquarters immediately!

Another *unfavorable* bill, HB 318 (Acupuncture), will soon be ready for debate in the House. Again, the chiropractors are working this bill *hard* and MSMA members MUST contract their *State Representatives* and express medicine's opposition to HB 318 if it is to be defeated in the House!

The MSMA *opposes* HB 318 because it would allow untrained persons to practice acupuncture after attending short seminars. Acupuncture is currently being studied by the National Institutes of Health and many other medical entities and has not yet been scientifically validated. For the protection of the public acupuncture should be considered "within the practice of medicine."

While discussing HB 318 with your Representative, members might add that medicine SUPPORTS two Senate bills which have recently passed the Senate and are awaiting House action.

The two favorable Senate bills are SB 1 (Surgicenters), which would provide for the licensing of surgicenters, and SB 458 (Malpractice Insurance), which would provide enabling legislation so that associations could establish mutual-type insurance companies for the medical profession.

Again, if MSMA members need to know the name of their Representative or need information on the above bills *contact* MSMA Headquarters immediately!!

* * *

Dr. Matthews has been requested by many MSMA members to publish the vote of HB 342 (Extension of Chiropractic) which was passed by the Missouri House three weeks ago.

The voting record is listed below. A "NO" vote SUPPORTS the MSMA's position.

★ ★ ★ ★

AYES — Representatives

Aikens
Arnold
Bailey
Banks
Barry
Becker
Betz
Binger
Blackwell
Blassie
Brockfeld
Bruckerhoff
Buechner
Burke
Calloway
Carrington
Cline
Copeland
Dames
DeCoster
Dirck
Doll
Drake
Dyer
Ellis
Esser
Fazzino
Feigenbaum
Hadley
Heflin
Hoffman (144)
Goode
Jones
Jordan
Kelly
Johnson
King
Kostron
Lewis
Kenton
Lynn
Maddox
Mareschal
Lowenstein
McBride
McCrary
McIntyre
Mathewson
Miller (121)
Muckler
Mueller (62)
Meyer
Mulvaney
Novinger
O'Connor
Mueller (93)
Ottinger
Piekarski
Quarles
O'Toole (55)
Riley
Rivers
Rojas
Quinn
Russell (58)
Russell (150)
Rust
Rothman
Scaglia
Schlef
Schnatmeier
Ryan
Sego
Sharp
Shear
Scott
Stone (71)
Sutherland
Treppler
Snowden
Vossmeyer
Watts
Welch
Villa
Young
Youngdahl
Zych
Williams
Mr. Speaker - 92

★ ★ ★ ★

NOES — Representatives

Baker (15)
Blakeley
Bockenkamp
Butts
Coleman
Countie
Davidson
DeField
Dickson
Downing
Durnell
Gann
Garrett
Griffin
Hamlett
Harmon
Hoblitzelle
Holliday
Holt
Howard (157)
Howard (49)
Huffman (91)
Kaye
Lang
Marriott
Martin
Mead
Mickelson
Miller (145)
Mitchell
Osbourn
O'Toole (97)
Perry
Proffer
Raisch (107)
Randall
Reisch (110)
Russell (6)
Schorgl
Schrader
Seay
Smith
Snyder
Sponsler
Stoner (147)
Stotts
Strong
Sweeney
Thomas
Thompson
Usher
Volkmer -54
Wallis
Westfall

Absent and absent with Leave — Representatives

Baker (27)
Curls
Dill
Donegan
Gardner
Goward
Hancock
Hedrick
Hoffman (89)
Leisure
Maloney
McCubbin
McKamey
Morgan
Nilges
Roderick - 17
Rollins

HEW proposes curbs on Medicare fees

Reimbursement of Physicians' Fees Under Medicare will be tied to economic indices so that Medicare costs, "will follow, rather than lead, any inflationary trends," according to regulations proposed April 14 by HEW.

The proposed regulations, which would implement Section 224A of the Social Security Amendments of 1972 (PL 92-603), are scheduled to become effective July 1. The government has provided 30 days for comment.

Under the regulations, economic index data would be developed to reflect changes in operating expenses of physicians in private practice and changes in the level of earnings by workers generally, and these would be applied to that protion of a physicians' revenue which is considered the physician's wage."

The regulations would continue the 75th percentile for reimbursement, based on fiscal year 1973 prevailing charges as adjusted to reflect charges in calendar year 1971. Any increase in the amount recognized as the prevailing charge in a locality would then be limited to the amount justified by the proposed national index. SSA said it expects the regulations to save $30 million during the first fiscal year.

The AMA opposed the proposed regulations when they were announced.

Dr. Howard J. McAlhany
Council Chairman

Dr. John N. Martin
Council Vice Chairman

Dr. Franklin is President-Elect

Dr. R. Allen Chandler assumes MSMA Presidency

R. Allen Chandler, M.D., of Kansas City, was installed as President of the Missouri State Medical Association during ceremonies at the 117th Annual Session, April 19, in St. Louis.

Dr. Chandler served as President-Elect the past year. He succeeds James C. Cope, M.D., of Columbia.

Max S. Franklin, M.D., of St. Louis, was unanimously selected President-Elect of the MSMA and will assume the Presidency at the 1976 Annual Session.

Dr. Franklin is Immediate Past Chairman of the MSMA Council and has served as Councilor from the Third District and Treasurer.

Delegates to the MSMA House elected a new AMA Delegate, a Speaker and Vice Speaker and three Vice Presidents.

Robert A. Slickman, M.D., of Kansas City, current Speaker of the House, was elected AMA Delegate to succeed Hector W. Benoit, Jr., M.D., of Kansas City, who did not seek re-election. Dr. Slickman will take office Jan. 1, 1976. Hubert A. Ritter, M.D., St. Louis, was re-elected as AMA Delegate and Lawrence W. O'Neal, M.D., St. Louis, and Hugh E. Stephenson Jr., M.D., Columbia, were re-elected Alternate Delegates.

Serving as Vice Presidents for the MSMA for 1975-76 are Drs. Lysle M. Bach, Hannibal; Fred D. Fowler, Kansas City; and T. Eugene Ruff, Poplar Bluff.

The House elected James T. Brown, M.D., Springfield, as Speaker and Edwin K. Burford, Jr., M.D., Cape Girardeau, as Vice Speaker.

In Councilor District elections conducted during the Annual Session, Dr. J. Russell Comer, Hannibal, was elected to succeed Dr. Bach in the second District and Dr. Donald R. Judd, St. Louis, was elected to succeed Dr. franklin in the Third District.

Four Councilors were re-elected to their posts. They are Dr. Louis P. Hetlage, Troy, Fourth District; Dr. William D. Bradshaw, Clinton, Sixth District; Dr. Howard J. McAlhany, Springfield, Eighth District; and Dr. Eugene T. Hansbrough, Poplar Bluff, Tenth District.

The Council met in an organizational meeting following the Annual Session and elected Dr. McAlhany as Council Chairman and Dr. John N. Martin, St. Joseph, as Vice Chairman.

The Council re-elected Dr. John I. Matthews, Jefferson City, as Secretary and elected Dr. Richard V. Bradley, St. Louis, as Treasurer.

Clock-radio winners listed

The winners of the four Panasonic three-band, clock-radios given as attendance prizes during the Annual Session in St. Louis were:

Dr. James H. Bryan, Clayton; Dr. Louis Keller, St. Louis, Dr. Kenneth Glover, Mt. Vernon, and Dr. Alex Harell, St. Louis.

Annual Session

Continued

AMA Tract V Program — Urged that the State Board of Healing Arts adopt the policy of accepting the "Fifth Pathway" for Missouri medical licensure.

Advertising — Asks for reconsideration of the AMA's policy on advertising by prepaid medical care plans.

Community Medical Directories — Endorses the AMA's policy that it is not unethical for a physician to list his name in a directory which is intended to list all physicians in the community on a uniform and non-discriminatory basis.

Interest Charged on Unpaid Accounts — Endorses AMA policy that it is unethical to charge interest on an unpaid account, but a service charge, equal to the acutal cost of the rebilling, may be added to the bill. Patients must be notified in advance of the existance of a service charge.

Senior Law Students — Instructs MSMA officers to write the Deans of law schools in Missouri in hopes of setting up a program where senior law students would observe medical emergency services over a 24-hour period with a senior surgical or medical resident. Aim is to promote better communications between professions.

THIRD PARTY PAYORS

Uniform Insurance Claim Form — Rejects the affidavit on the reverse side of the AMA's Uniform Insurance Claims Form as unacceptable and demeaning to physicians.

Reimbursement to Surgicenters — Urges all Blue Cross plans using the "cost'plus" concept in contracts with ambulatory surgical care facilities to delete that requirement.

Refusal of Payments — Requests General American to identify the makeup of its "informal review committee," explain the type of review it carries out and provide specific reasons for refusal of physician payments.

LEGISLATION

Licensing Power of Board of Healing Arts — Opposes any legislation which dilutes the licensing power of the Missouri Board of Registration of the Healing Arts. Encourages passage of laws to aid Board in licensing physicians of ethical and moral character.

Physician Assistants — Opposes any attempt to amend the physician assistant training act.

Federal Relicensure — Opposes current Health Manpower Act before Congress.

Membership in MSMA sets record in 1974

Membership in the Missouri State Medical Association set a new record in 1974.

The final audit, effective December 31, 1974, showed that total membership in the MSMA had grown to 4,672 — an increase of 203 members over the 1973 total of 4,469.

A breakdown of the total shows:

	1973	1974	Increase
Active	3,957	4117	160
Junior	105	139	34
Honor	407	416	9

Active membership in the American Medical Association by MSMA members also increased in 1974. Missouri's total active AMA membership in 1974 was 3,795, a 110 increase over the 1973 total of 3,685.

Hospital Discharge data backed in legal opinion

The controversial uniform hospital discharge data project proposed by the Missouri Board of Health has received the support of the State Attorney General's office.

In an opinion issued April 23, the Attorney General stated that "the State Board of Health is authorized by law to adopt and enforce regulations requiring hospitals licensed by the state to submit reports containing certain data relating to hospital discharges."

The Attorney General added that, in his opinion, the confidentiality of the physician-patient relationship will not be disturbed by the Board's regulations because neither the names nor addresses of patients and physicians will be revealed to the Board.

The discharge data form distributed by the Board asked for the following information for inclusion in a required monthly report:

(1) Patient's hospital code number; (2) patient's year of birth; (3) patient's sex; (4) patient's race; (5) patient's residence by state, county, and zip code, census tract, or rural route; (6) hospital code number; (7) admission date and hour; (8) discharge date; (9) attending physician by hospital code number; (10) operating physician by hospital code number; (11) diagnosis according to international classification of diseases; (12) disposition of patient (home, nursing home, funeral home, etc.); (13) expected source of payment for patient's care and treatment; (14) service in hospital from which patient discharged; (15) medical procedures performed on patient during hospitalization and dates performed.

MSMA President objects to Health Manpower bill

A proposed Health Manpower bill before Congress has been termed objectionable by Dr. R. Allen Chandler, MSMA President, in a letter to Rep. James Symington, D-St. Louis.

Rep. Symington is a member of the House Interstate and Foreign Commerce Committee which is expected to hear the bill soon.

In opposing H.R. 5546, Dr. Chandler pointed out that the bill would establish Federal control of the number and location of medical residencies and would require that all medical students repay the government for Federal aid to medical schools.

Dr. Chandler said that the control of residencies has been and should continue to be the concern of the Coordinating Council on Medical Education and other involved organizations.

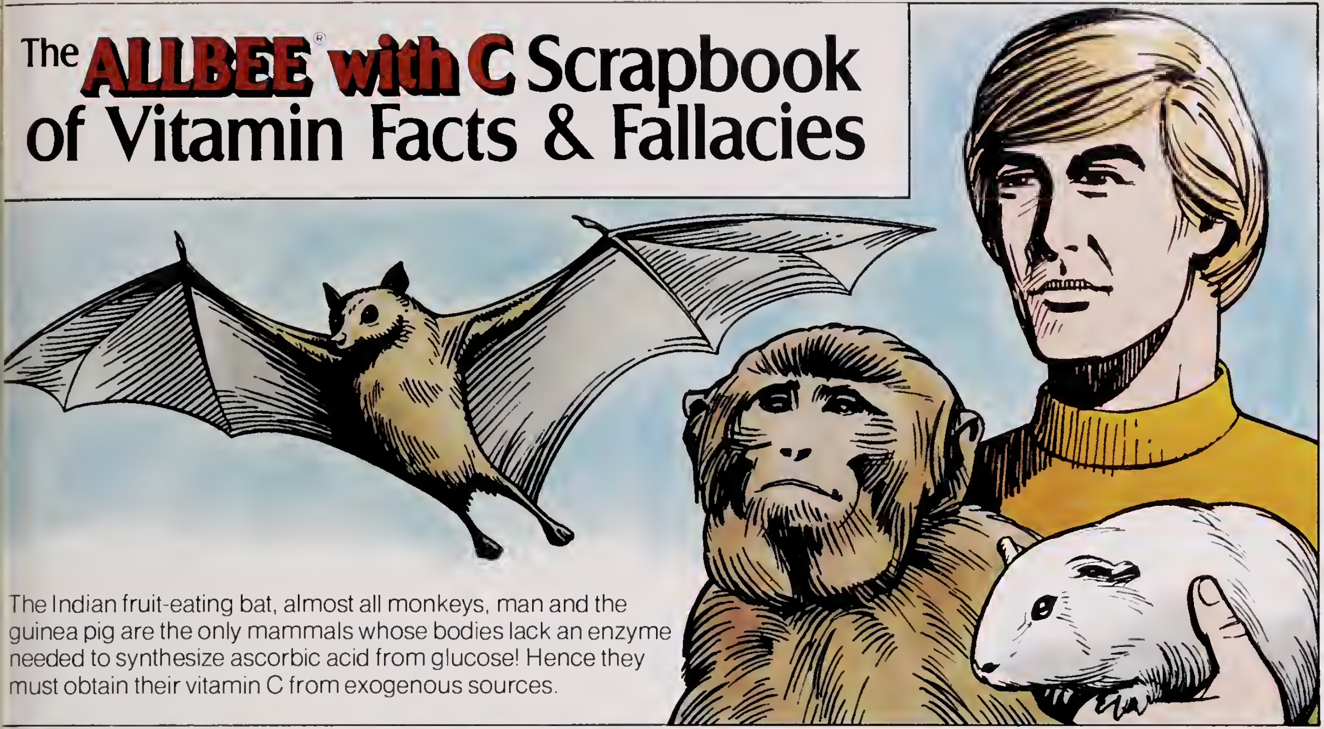
"The imposition of Federal law," continued Dr. Chandler, "could force disruption of many programs, affecting the education of residents and the care provided by institutions."

Concerning the requirement that medical students must repay capitation grants to schools, Dr. Chandler said that this provision was without precedent and was discriminatory against medical students.

"This amounts to a forced loan, to mandate service in shortage areas defined by the Department of HEW," he added.

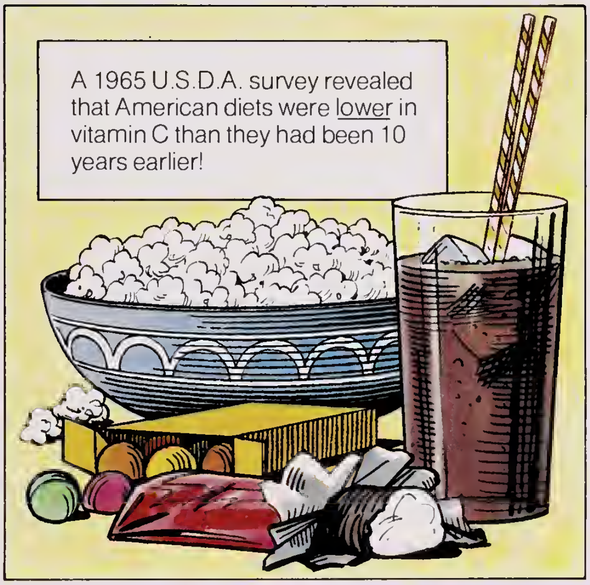
Dr. Chandler stated that the best way to attract medical professionals to shortage areas is through mechanisms which allow the individual to voluntarily commit himself to service in a needy area. This can be accomplished through such programs as the National Health Service Corps, scholarships for service in shortage areas, loan forgiveness or similar voluntary programs.

The ALLBEE® with C Scrapbook of Vitamin Facts & Fallacies



The Indian fruit-eating bat, almost all monkeys, man and the guinea pig are the only mammals whose bodies lack an enzyme needed to synthesize ascorbic acid from glucose! Hence they must obtain their vitamin C from exogenous sources.

De Joinville writing about a 13th century crusade reported that barber surgeons had to "cut away the dead flesh from the gums to enable people to masticate their food." The disease he described was probably scurvy.



A 1965 U.S.D.A. survey revealed that American diets were lower in vitamin C than they had been 10 years earlier!

The outer leaves of cabbage and brussels sprouts contain more vitamin C than the heads. Yet, ironically, these are often trimmed away by the grocer to improve appearance and enhance sales appeal! Many housewives trim them even more before cooking!

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Pyridoxine hydrochloride (B_6) 5 mg *
Niacinamide 50 mg 500%
Calcium pantothenate 10 mg **
Ascorbic acid (Vitamin C) 300 mg 1000%
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atropine sulfate	0.0194 mg.	0.0194 mg.	0.0582 mg.
hyoscine hydrobromide	0.0065 mg.	0.0065 mg.	0.0195 mg.
phenobarbital	(¼ gr.) 16.2 mg.	(½ gr.) 32.4 mg.	(¾ gr.) 48.6 mg.
(warning: may be habit forming)			

Brief summary. Adverse Reactions: Blurring of vision, dry mout difficult urination, and flushing or dryness of the skin may occur c higher dosage levels, rarely on usual dosage. Contraindicatior Glaucoma; renal or hepatic disease; obstructive uropathy (for e ample, bladder neck obstruction due to prostatic hypertrophy); hypersensitivity to any of the ingredients.

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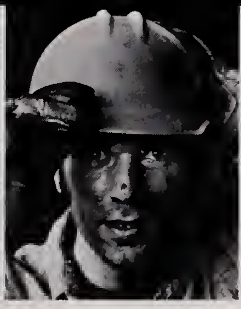
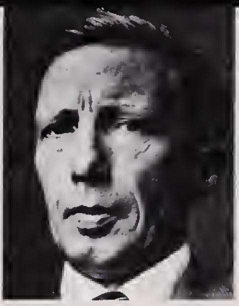
hma or allergy



The patient with
gastritis

The patient
on uricosurics

The patient
on anticoagulants



The peptic ulcer
patient

The febrile,
dehydrated child

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ovide an added margin of safety
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cetaminophen) to all the patients in your practice who require an analgesic-antipyretic?

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Drops, 60 mg./0.6 cc. (alcohol 7%).
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yet just as effective for
relief of pain and fever**
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in Brief

A summary of AMA, medical & health news

American Medical Association/535 North Dearborn Street/Chicago, Illinois 60610/Phone (312) 527-1500/TWX 910-221-0300

The date for implementation of utilization review regulations in hospitals and other health facilities participating in Medicare and Medicaid programs was extended from Feb. 1, 1975 to July 1 by HEW Secretary Caspar Weinberger. He said the reason for the extension was to "allow all providers to come into full compliance and to avoid the loss of eligibility to participate in Medicare and Medicaid programs before July 1." The AMA, joined by ten patients and five Illinois physicians, filed its first suit ever against HEW on February 20 to seek both a preliminary and permanent injunction against implementation of the regulations. In addition, Weinberger heard opposition to the regulations from the American Hospital Association and the Oklahoma Congressional delegation, which pointed out the difficulty of implementing the rules in small rural hospitals.

Government officials assured the medical profession of their complete cooperation in an effort to avert a critical shortage of opium-based medications. At a meeting called by the AMA, HEW said there will be no shortage of codeine in 1975, but reserve stocks will be seriously depleted. The government agreed with the AMA that growing the papaver bracteatum poppy in the U. S. should be seriously investigated. Later, in testimony before the Senate Juvenile Delinquency Subcommittee, Jerome H. Jaffe, M.D., former head of the Special Action Office for Drug Abuse Prevention, said that the agreement with the Turkish government to ban opium poppy cultivation failed to solve the heroin addiction problem in this country, but probably contributed to the shortage of opium-derived drugs for medical uses.

The U. S. infant mortality rate set a record low in 1974, 16.5 per 1,000 live births. It is a 6.8% decrease from the 17.7 per 1,000 in 1973.

Under a new continuing medical education record-keeping system, participating state and specialty medical societies would receive transcripts periodically for dissemination to their members. The continuing medical education records would be maintained on the computer at AMA headquarters. The system is an expansion of the AMA's American Medical Computer Assistance Program. Two state societies and one specialty society plan pilot programs of the continuing medical education system.

The AMA requested withdrawal of proposed MAC regulations published by HEW. The rules, which seek to establish a Maximum Allowable Cost reimbursement for drugs furnished under programs within the jurisdiction of HEW, are not supported by law, they constitute an interference in the practice of medicine and the assumption upon which they are based—equivalency of chemically equivalent drugs—does not have a scientific foundation, the AMA said. In a statement submitted to the Senate Monopoly Subcommittee expressing its opposition to the rules, the AMA said, "We have indicated our intention to pursue this opposition through litigation in the event that HEW persists in its position by finalizing the regulations as proposed."

Medical care costs are rising according to the February Consumer Price Index. The medical care sector showed price increases that month that were above those in the economy in general and the all services sector in particular. The all items category rose 0.7% in February, compared to 0.5% in January. The all services index rose 0.8%, the same increase as in January. Both the medical care component and the physicians' fees rose by 1.2%. The increase in the medical care component was slightly less than the 1.3% increase in January, but the increase in physicians' fees was higher than the January increase of 0.9%.

The American Medical Student Assn. is the new name of the former Student American Medical Assn.

medical melange

Notes of interest from Here . . . . and There

Dr. Emmett Hoctor, director of community psychiatry at Farmington State Hospital, celebrated his 50th anniversary at the Hospital on April 1. He became superintendent of the Nevada (Mo.) State Hospital at the age of 28 and was appointed superintendent of the Farmington State Hospital in 1925. He served in this capacity until 1963 when he transferred to his present position. Dr. Hoctor was the recipient of the *St. Louis Globe Democrat's* Distinguished Service Award in 1971. He has disclosed plans to retire "in six months or so."

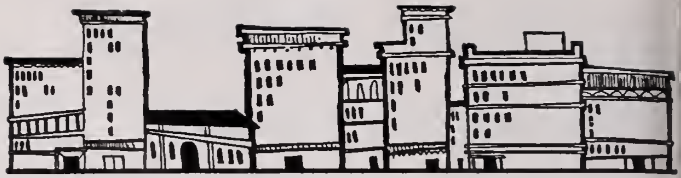
Dr. T. M. Macdonnell of Marshfield has been appointed to the Board of Regents of Southwest State University by **Gov. Christopher Bond.** Dr. Macdonnell is president of Webster County Medical Association and a member of the Marshfield Board of Education. The appointment is subject to confirmation by the Missouri Senate.

Dr. Arthur E. Baue, surgeon-in-chief and director of the Department of Surgery at the Jewish Hospital in St. Louis, received an alumni achievement award at the annual meeting of Westminster College's National Alumni Association on May 3 in Fulton. Dr. Baue was graduated from Westminster College summa cum laude in 1950. A convocation honoring the alumni award winners was held in the reconstructed Christopher Wren church on the Westminster campus. Dr. Baue also is Edison Professor of Surgery at Washington University School of Medicine.

Dr. Paul Barone, superintendent of the Nevada State Hospital, was honored in April by the Missouri Division of Mental Health for his 35 years of service to the state hospital. A pin signifying the completion of these years of service was presented to him in a special ceremony by **Dr. E. C. Francisco,** assistant superintendent. Dr. Barone became superintendent of the Nevada State Hospital in 1940 and held that post until April, 1970 when he became clinical director. He was reappointed as superintendent in November, 1972 when **Dr. Derek Hughes** was transferred to the staff of the Division of Mental Health in Jefferson City.

President Gerald R. Ford has nominated Dr. **Theodore Cooper,** now of Bethesda, Md., as assistant secretary for health for the Department of Health, Education and Welfare to succeed **Dr. Charles C. Edwards,** who resigned on January 5. Dr. Cooper is a graduate of the St. Louis University School of Medicine and was a member of the faculty for six years. He was a member of the St. Louis Medical Society until the fall of 1974. He has served as chief deputy to Dr. Edwards and as director of the National Heart and Lung Institute. He has been the acting assistant secretary for health for HEW since January 5.

From the Medical Schools



WASHINGTON UNIVERSITY

About 10% of the children and adolescents treated at the School of Medicine Child Guidance Clinic are suffering from depression.

Depression has a variety of causes, explained *Doris C. Gilpin*, M.D., instructor of child psychiatry and associate director of the Child Guidance Clinic. "Loss of a significant figure in a child's life can lead to depression," she explained, "or if a child is often criticized or is failing frequently, he can get the feeling that he really isn't much good."

Area professionals interested in learning to recognize the symptoms of depression in children and adolescents, as well as possible treatment, attended a course sponsored by the Child Guidance Clinic and the Washington University Department of Psychiatry on April 24-25.

E. James Anthony, M.D., Blanche Ittleson Professor and Head of the Division of Child Psychiatry, participated in the course along with two guest lecturers.

Dr. Anthony spoke on the clinical aspects and treatment of the depressed child and adolescent and discussed data from the guidance clinic, which was presented by *Judith Schechtman*, M.S.W.

Carl P. Malmquist, M.D., from the University of Minnesota, discussed the theory of depression in children. He is a professor of child development and of law and criminal justice. He also is a consultant to the Lansing (Minn.) school system.

Albert C. Cain, Ph.D., professor of psychology at the University of Michigan, spoke on children's reaction to parental suicide and death of a sibling.

Joseph M. Davie, M.D., Ph.D., has been named professor and head of the Department of Microbiology at the School of Medicine.

Dr. Davie, who has been associate professor of microbiology and of pathology, replaced *Herman N. Eisen*, M.D., who resigned in June, 1973 to accept a position of professor of immunology in the Department of Biology at the Center for Cancer Research, Massachusetts Institute of Technology. *Milton J. Schlesinger*, Ph.D., has served as acting director during the interim.

Dr Davie joined the medical faculty in 1972. In 1973, he was named Director of Graduate Studies in experimental pathology.

Dr. W. Edwin Dodson, instructor in pediatrics and neurology at Washington University-St. Louis Children's Hospital, has been awarded a $60,000 March of Dimes clinical research grant.

Dr. Dodson will study the extent to which certain drugs, prescribed for women by their physicians for medical reasons and used during the final weeks or days of pregnancy enter their unborn babies' bloodstreams. The investigation focuses on tranquilizers, sleeping compounds, local anesthetics and anticonvulsants and the possible harmful effects on normal or ill newborns.

UNIVERSITY OF MISSOURI-KANSAS CITY

The second annual meeting of preceptors was held at the School of Medicine on April 5. Attending were family physicians who participate in the summer family medicine preceptorship for Year 2 students in the School of Medicine. A program during the day consisted of a discussion of the development of the School of Medicine and its preceptorship program. It was followed by a scientific session which included a physical diagnosis demonstration in cardiology by *Robert Conn,* M.D. and a presentation on oral medication in diabetes by *Nathaniel Winer,* M.D.

A banquet was held at the Crown Center Hotel in the evening. Speakers were students from the Year 2 class of last year who emphasized the importance of the summer preceptorship program to their understanding of family medicine and the need for primary care physicians.

It is anticipated that the preceptors will meet annually at the School of Medicine. The meetings will be held in conjunction with the annual meeting of the Missouri State Medical Association when it meets in Kansas City on alternate years.

Hebbel E. Hoff, M.D., Ph.D., was a Visiting Docent at the School of Medicine from March 3 through March 14. Dr. Hoff is Benjamin F. Hambleton Professor and Chairman, Department of Physiology, Baylor College of Medicine. On March 14, Dr. Hoff presented the University Hour, "A Cajal Pilgrimage and the Cajal Paintings."

A total of 456 Missouri high school seniors have pplied to the School of Medicine for the first-year lass beginning this fall. Ninety-eight of these indiiduals are from rural counties which lie outside he standard metropolitan statistical area counties f Missouri. The metropolitan area counties are hose in population areas of 50,000 or greater.

T. LOUIS UNIVERSITY

Dr. George E. Gantner, Jr., professor of forensic nd environmental pathology and St. Louis County nedical examiner, has been elected to the executive ommittee of the American Academy of Forensic ciences for a three-year term through 1978. In his capacity, he will represent the interests of all orensic pathologists in North America in the excutive committee deliberations of the Academy. ormed in 1949, the Academy is a multidisciplinary rganization representing criminalistic, jurisprulence, forensic dentistry, physical anthropology, orensic psychiatry, questioned documents and toxcology in addition to the forensic pathology and iology section.

Goals of the Academy include the constant uprading of police laboratories, criminal justice and nedicolegal systems by providing scientific symosia and seminars to a broad spectrum of memberhip.

A special immunization program for elementary chool children in the Normandy School District vas conducted in April by a team of medical stulents from St. Louis University School of Mediine. The project was sponsored by the Department f Community Medicine which is under the direcion of *Dr. Max P. Pepper.* The program provides reshmen medical students with practical exposure o community health problems and direct experince in health service delivery. Approximately 1500 tudents from both parochial and public schools vere immunized in the four-day project.

Winners of the tenth annual Alpha Omega Alpha Research Forum have been announced by the School of Medicine. First place winner was *David A. Bryce,* a sophomore, “Studies with Somatostatin: A New Hypothalmic Hormone.” Tied for second lace were *Robert L. Coffey,* a junior, “Characterization of the Phosphate Bond in the Calcium Pump f Rabbit Sarcoplasmic Reticulum,” and *Marilyn F. M. Johnston,* a senior, “Mechanisms of Inhibition f Adoptive Transfer of Tuberculin Sensitivity in Uremia.”

Dr. Max S. Franklin Named MSMA President-Elect

Max S. Franklin, M.D.

Max S. Franklin, M.D., St. Louis, was elected President-Elect of the Missouri State Medical Association on April 20 at the final meeting of the House of Delegates during the 117th Annual Session at the Chase-Park Plaza Hotel in St. Louis.

Dr. R. Allen Chandler, Kansas City, was installed as President of the Association at the Session.

Dr. Franklin is a Past-President of St. Louis Medical Society. He was treasurer of the Missouri State Medical Association in 1968-1970, was elected Councilor of the MSMA Third District in 1971 and is the Immediate Past-Chairman of the Council. He is a member of the Board of Trustees of the Missouri State Medical Foundation.

Dr. Franklin is a graduate of Harvard University and received his M.D. degree at St. Louis University School of Medicine. A specialist in internal medicine and cardiology, he is Assistant Clinical Professor of Internal Medicine at St. Louis University.

Dr. Franklin served as Flight Surgeon in the Army Air Force in 1942-1946. He is a member of the Southern Medical Association, a National Past-President of Phi Delta Epsilon Medical Fraternity and has served as President of the Board of Trustees of Phi Delta Epsilon.

Dr. and Mrs. Franklin are the parents of a daughter, Dale.

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Risk and Utility of Platelet Transfusion

NCREASINGLY, BLOOD BANKS are splitting whole lood into its component parts for greater safety transfusions and maximum efficiency in utilizg donor resources. This has resulted in a marked crease in the availability of platelet concentrates hroughout the state of Missouri.

Transfusions of platelet concentrates, while fesaving in many cases, involve risks which are ifferent and often more subtle than the risks of ansfusing red cells or plasma components. Some f these risks are related to factors in the potential ecipient. In this article, we attempt to outline ese risk factors and define indications and relave contraindications to platelet concentrate transsions.

. RISK FACTORS RELATING TO PLATELET CONCENTRATES

. *Risk of Infection*

In addition to the usual risks of transmitting epatitis, syphilis, malaria and other blood-borne fections, platelet concentrates carry an extra risk ecause of the method of storage.[1,2] Whether latelets are best preserved at refrigerator or room mperature is not settled at present. However, ey are now commonly stored at room temperare. Any microorganisms present would be more kely to grow at this temperature. Transfusion of ch a contaminated unit would provide a massive noculum to the recipient, who might have dereased host resistance. Since platelet concentrates re cloudy from the platelets themselves, such conmination would likely escape detection by visual spection. The fact that this complication is rare provides little comfort, since the consequences may be fatal.

B. *Risk of Sensitization of the Host to Platelet Antigens.*

Platelets carry on their surface the major histocompatibility antigens of the HL-A system.[3–5] Since the usual platelet transfusion practice cannot take into consideration the matching of donor HL-A type to that of the recipient, such nonmatched or random platelet transfusions eventually cause the recipient to produce circulating antiplatelet antibodies. The risk of producing antibodies increases with the number of platelet transfusions given. When present, these antibodies cause immediate destruction of transfused platelets from random

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Platelet concentrates are becoming more widely available. Their use entails special risks in addition to those common to most transfusion therapy. A major consideration is that not all thrombocytopenic patients are candidates for platelet transfusions. The authors warn general physicians about the risk as well as review indications for these tranfusions. Dr Brubaker is Associate Professor of Medicine (Hematology/Oncology) and Dr. Rosenstein was Associate Professor of Pathology and Director of the Blood Bank, University of Missouri Medical Center at the time this paper was written. He is now a pathologist for the Missouri Delta Community Hospital in Sikeston.

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donors. This produces a refractoriness to platelet transfusions and an increased risk of febrile transfusion reactions.

In this situation, the major risk to the patient is not in the reactions that are produced, but in the fact that because of previous platelet transfusions, effective hemostasis may be denied him at a critical juncture in his management. When repeated platelet transfusions become necessary for patient support, the refractoriness to these transfusions may appear within as little time as a week or two or may take months to develop. The length of time seems to depend on whether the patient is competent or incompetent immunologically. The HL-A antibodies so induced also might reduce the possibility that the patient may undergo a successful transplant, such as a marrow transplant if he is a patient with aplastic anemia.

II. Risk Factors Relating to the Recipient

Not all thrombocytopenic patients are candidates for platelet transfusions. Thrombocytopenia may be caused by marrow failure or increased peripheral destruction of platelets. The current most practical way of differentiating between these possibilities is to perform a bone marrow aspirate or biopsy or both. If megakaryocytes are plentiful in a marrow of adequate cellularity, one may presume that lack of marrow production is not causing the thrombocytopenia. Failure to differentiate the pathophysiological causes of thrombocytopenia may lead to inappropriate treatment.

Transfusing platelets to patients who have a common cause of platelet destruction, disseminated intravascular coagulation (DIC), may be likened to pouring gasoline on a fire. Of course, this might not be true if adequate recognition of the DIC leads to appropriate therapeutic measures. Most importantly, these include elimination of the underlying cause or, secondarily, heparin therapy to interrupt further fibrin deposition in the blood vessels. Similarly, giving platelets to patients who have thrombocytopenia due to immune destruction is usually ineffective, subjecting the patient to the risks of platelet transfusion with little benefit. These patients might need corticosteroid therapy, splenectomy, or possibly, only watchful waiting, such as in children.

III. Indications and Relative Contraindications for Transfusion of Platelet Concentrates

A. *Indications*

The primary reason to transfuse platelets is to stop bleeding caused by inadequate platelet numbers or function. Platelet function may be inadequate despite normal counts. This can be due to intrinsic platelet defects or extrinsic defects caused by such common, nonprescription drugs as aspirin[6] and glyceryl guaiacolate.[7] Other drugs, available by prescription only, such as nitrofurantoin, clofibrate, dypyridamole, chlorpromazine, imipramine, amitryptyline, anesthetic agents and high doses of penicillin G, can inhibit platelet function.[8] When the patient is bleeding and either is thrombocytopenic, has inadequate clot retraction or a prolonged bleeding time by the Mielke technique,[6] platelet transfusions may be lifesaving.

Platelet transfusions also are indicated to attempt to prevent bleeding in patients who are temporarily thrombocytopenic from anticancer chemotherapy. The biggest concern is that the patien may develop intracranial bleeding that would be fatal before it could be stopped. Prophylactic platelet transfusions often are given whenever the platelet count falls to less than 10-20,000/mm (or higher if clinical experience indicates that the particular patient bleeds at higher count levels).

Balanced against the benefits of prophylactic platelet transfusions must be the risk of premature induction of antiplatelet antibodies. A common indication for prophylactic transfusions occurs in the chemotherapy of acute leukemia. Modern chemotherapy can produce prolonged remissions, and in children, perhaps, even cures.[9] However, there is often a period when the risk o bleeding is extreme. This risk can be markedly reduced with such prophylactic transfusions. Should these transfusions be started early, though, the patient might become refractory to them at the mos critical time when the bone marrow is maximall suppressed from treatment.

A practical means of reducing risk of bleedin in thrombocytopenic patients is to prevent their ingestion of medicines containing aspirin or glycery guaiacolate. These are ingredients in many popula prescription and over-the-counter medications, suc as pain, cough or "cold" remedies. Patients ofte do not realize this and may not even tell the docto they are taking one of these. We have recently see a thrombocytopenic patient with leukemia wh stopped bleeding into her skin after discontinuin a cough medicine containing glyceryl guaiacolat No platelet transfusions were given, and her platelet count remained unchanged at 30,000/mm^3.

(Continued on page 237)

CHARLES B. ANDERSON, M.D., JOHN E. CODD, M.D.,
RALPH J. GRAFF, M.D., JOHN G. GREGORY, M.D.,
BRUCE A. LUCAS, M.D., *and*
WILLIAM T. NEWTON, M.D., *St. Louis*

Renal Transplantation

Since the first renal transplants were performed in Missouri in 1963, there have been appoximately 265 transplants. The need and demand for the transplants in the Missouri area are increasing. This paper encompasses the present status of renal transplantation for the information of the practicing physician. It was originally presented in part at the Missouri Chapter of the American College of Surgeons meeting in Kansas City in 1973. The authors are from the Departments of Surgery, Washington University and St. Louis University schools of medicine.

THE STATUS of renal transplantation was last reviewed in MISSOURI MEDICINE in 1965.[1] Because renal transplantation was then still in the experimental stages, it was cautioned that an over enthusiastic, uncontrolled approach to this procedure be avoided. However, the development of this field has advanced rapidly, so that renal transplantation is no longer considered an experimental procedure but is recognized as an accepted method for treating end stage renal disease. In addition, renal transplantation may be beneficial in treating enzyme defects which are present in Fabray's disease and cystinosis.[2]

With regard to the choice of managing patients by hemodialysis or renal transplantation, there is general agreement in three main areas. The first is that successful renal transplantation is preferable to chronic hemodialysis because it more effectively rehabilitates the patient. The second is that sibling renal transplantation almost always should be recommended over dialysis as the quality of life is better with the former and the survival rates are similar with both methods of treatment.[3] Some feel that except for HL-A identical siblings, however, cadaver kidney transplants are preferable since the long-term results are the same, both in non-HL-A identical siblings and cadaver kidney transplants.[4] The paucity of available cadaver kidneys in most areas of the country precludes implementation of this latter approach, and the use of related living donors is preferred by most renal transplantation surgeons. Finally, renal transplantation in children has become well established with results equal to those in adults. Since children do poorly on chronic hemodialysis and fail to mature sexually or grow, renal transplantation is the treatment of choice for terminal renal failure in children.[5] Infants have received transplants, but not routinely. Procedures with this very young group of patients must be considered experimental.

Recent passage of HR-1 by the Congress has made available to a large segment of the population, as of July 1, 1973, treatment for end stage renal disease by hemodialysis or renal transplantation. It is estimated that 80% to 90% of the population will be eligible to receive benefits under this new legislation. Because of the anticipated need and demand for renal transplantation, physicians in the community will become more frequently and closely associated with recipients, donors and relatives who will seek assistance and guidance about renal transplantation from their personal physicians. It is not our intention to exhaustively review the literature on renal transplantation as this has been done in several excellent recent publications.[6-10] Rather, it is our aim to present a concise clinical summary in order to assist those physicians who may have need to refer patients for transplantation, to care for patients after renal transplantation or to participate in organ harvesting.

ACS/NIH ORGAN TRANSPLANT REGISTRY

An Organ Transplant Registry, which is maintained in Chicago under the direction of Dr. John Bergan, is sponsored by the American College of Surgeons and the National Institutes of Health.

TABLE 1

DISTRIBUTION OF RENAL DISEASES REQUIRING TRANSPLANTATION

	%
Glomerulonephritis	59
Pyelonephritis	15
Other diagnoses	14
Polycystic kidneys	5
More than one disease	4
Nephrosclerosis	3

TABLE 2

DONOR TYPE

Cadaver	
Sibling	
Parent	
Unrelated living	<
Child	<

The Renal Transplantation Section of this registry was started in Boston ten years ago by Drs. Murray, Barnes and Atkinson. The wide acceptance of this registry by the transplant community has made possible an assessment of renal transplantation results throughout the world. The Eleventh Renal Transplant Registry Report was made available in December, 1973[11] and includes data on more than 12,000 renal transplants performed up until Jan. 1, 1973. The most recent data on numerous aspects of renal transplantation are available from the registry at any time.

Renal Disease

Once end stage renal failure has developed, it often is difficult to diagnose accurately the primary renal disease. Nevertheless, some 35 different diagnoses of renal failure have been entered in conjunction with renal transplantation. However, only four types of primary renal disease make up the majority of cases (Table 1). Glomerulonephritis and pyelonephritis account for 59% and 15% of the disease, respectively. Polycystic kidney disease and nephrosclerosis from malignant hypertension each account for about 3% to 5%. Some 30 additional entities are combined in the 14% of "other" diagnoses. Successful renal transplantation has been performed for lupus nephritis, diabetic glomerulosclerosis and Goodpasture's syndrome and in the presence of obstructive uropathy when ileal segment diversion or other procedures have satisfactorily corrected the obstruction.

Transplantation Statistics

As of Dec. 31, 1973, approximately 15,966 renal transplants had been performed in 14,465 patients by 280 transplant teams throughout the world.[12] It is estimated that 9,838 of the transplants were done in the United States and the remainder in other countries. The longest presently surviving patient with a renal transplant received his graft from a monozygotic twin 17½ years previously. Of all renal transplant patients, 67% are alive ar three fourths of these are sustained by a functioi ing graft. Of the patients dying at any time aft transplantation, 60% have functioning grafts. Se ond transplants constitute slightly less than 10% the total, and third transplants slightly less th 1%.

Donors

Over the past six years, there has been a trend t ward an increased use of cadaver kidneys and a d creased use of kidneys obtained from related li ing donors (Table 2). The use of cadaver kidne rose from approximately 45% in the period b tween 1953 and 1966 to 65% at the present tim Cadaver donors constitute an even larger percen age of cases in Canada (90%), Australia (96 and Europe (78%). The use of sibling donors h remained constant at about 20%, but the use parent donors has decreased from 25% to 15%, ar the use of unrelated living donors from 10% practically zero.

Results

The results of renal transplantation are trad tionally and best expressed in life table-ty graphs according to the type of donor. It shou be emphasized that the results are in terms graft function and *not* patient survival and th patient survival is on the average of 5% to 1 greater than kidney survival. The results over t 16-year period from 1951 through 1966 represe the earliest clinical results in a developing field ar are often separated from the more recent e perience. For the last four years in which two-ye results are available, there has been no statistic improvement in graft survival of sibling, parent or cadaver grafts. Fig. 1 demonstrates that the tw year results in sibling transplants has remained approximately 80%. In Fig. 2, the results of pare donor transplants demonstrates that the resu over the last four years do not show any statistic difference and that the two-year functioning ki

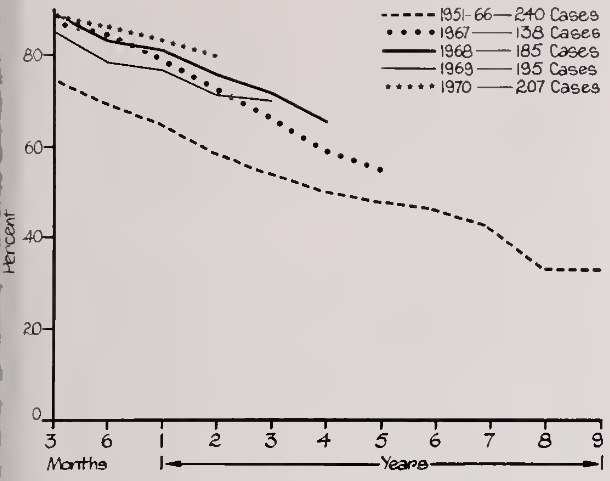

Fig. 1 Duration of renal transplant function using sibling donors. (By permission from the Tenth Report of the Human Renal Transplant Registry. Prepared by the Advisory Committee to the Renal Transplant Registry. JAMA 221:1495-1501, 1972)

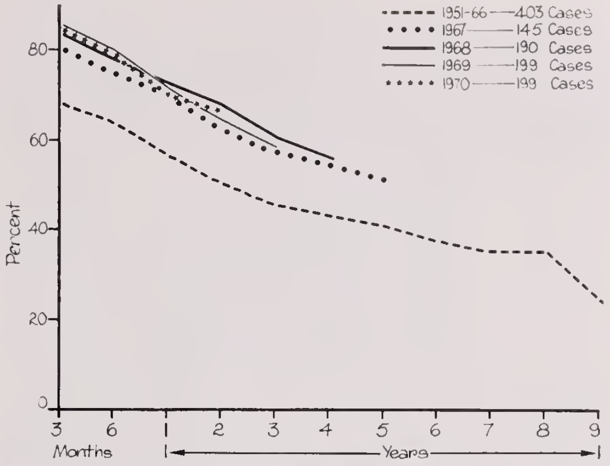

Fig. 2 Duration of renal transplant function using parent donors. (By permission from the Tenth Report of the Human Renal Transplant Registry. Prepared by the Advisory Committee to the Renal Transplant Registry. JAMA 221:1495-1501, 1972)

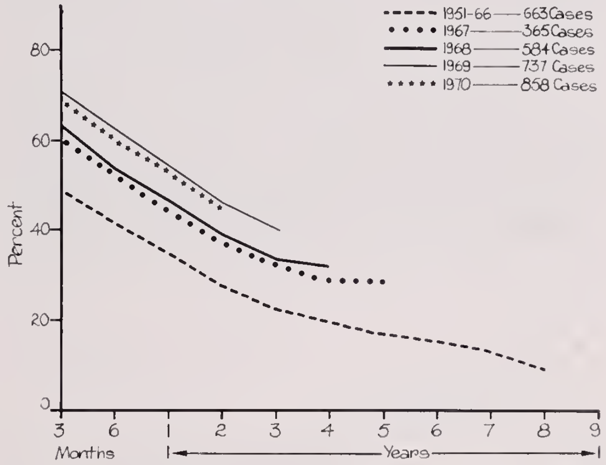

Fig. 3 Duration of renal transplant function using cadaver donors. (By permission from the Tenth Report of the Human Renal Transplant Registry. Prepared by the Advisory Committee to the Renal Transplant Registry. JAMA 221:1495-1501, 1972)

ney rate remains at about 70%. Fig. 3 shows that the results with cadaver kidneys is about 45% to 50% at the end of two years and that there has been no statistically significant improvement in graft survival since 1967. To summarize, the chance of successful renal function at the end of two years with sibling donors is 80%, with parental donors 70% and with cadaver donors 45% to 50%.

TISSUE TYPING

The importance of tissue typing in predicting the results of sibling renal transplants is well established with several centers reporting a 95% success rate when transplants are performed between HL-A identical siblings. However, there is disagreement with regard to its usefulness in cadaver transplantation.[13-19] In general, reports from the United States have not demonstrated any correlation between tissue typing and cadaver renal transplant success rates. However, large centers in Europe have noted significant correlations between HL-A matching and cadaver transplant results. The greater heterogeneity of the American population may contribute to this difference. Nonetheless, tissue typing continues to be used in selecting recipients of cadaver kidneys and every effort is made to find A-Match combinations.

A lymphocytotoxicity cross match which tests the recipient's serum against the donor's lymphocytes is performed prior to each transplant. If the test is positive, it indicates the presence in the recipient of antibodies against the donor's cells and precludes transplantation because of an 80% hyperacute rejection rate. This presensitization is often the result of multiple bood transfusions while on hemodialysis, infections or previous unsuccessful renal transplantation. Interestingly, there has been some recent evidence to indicate that those individuals who have received multiple blood transfusions and do *not* develop antibodies have more successful renal transplants than those patients who never receive blood transfusions.[20] Perhaps the absence of antibodies after multiple blood transfusions is indicative of a general inability to mount an immune response.

REJECTION AND INFECTION

Rejection and infection continue to be the two major complications of renal transplantation. At-

TABLE 3

CENTERS PERFORMING RENAL TRANSPLANTATION IN MISSOURI

Columbia	University of Missouri
Kansas City	University of Kansas
	Research Hospital
	St. Luke's Hospital
	Veterans Administration Hospital
St. Louis	Barnes Hospital
	Deaconess Hospital
	St. Louis University Hospital
	Veterans Administration Hospital

tempts to improve graft survival over the past four to five years by instituting a variety of immunosuppressive drug regimens have not been successful, and azathioprine, cyclophosphamide and corticosteroids continue to be the mainstays of immunosuppression. The efficacy of antilymphocyte globulin (ALG), although championed by some, has not been proven to the satisfaction of all.[4]

To avoid the horrendous infectious complications which attend aggressive and prolonged treatment of allograft rejection by large doses of corticosteroids, many centers have developed a policy of limited treatment of second and third rejection reactions and pursue a course of early retransplantation.[4] The ultimate solution to the problem of rejection and infection may lie in the area of selective suppression of the immune mechanism by either establishing tolerance or enhancement. Preliminary clinical studies in this area have begun with some initially encouraging results.[21]

MISSOURI

To the best of our knowledge, three cities and nine hospitals have been involved with renal transplantation in Missouri (Table 3). The first renal transplants in Missouri were performed in 1963. Since then, there have been approximately 265 transplants through Dec. 31, 1973. The longest survivor received a cadaver transplant nine years ago without the benefit of tissue typing and is presently in good health with a functioning graft.

As in other states, the large majority of transplants have been done over the past three years because of the increased acceptance of renal transplantation as an effective and practical means of treating end stage renal disease. The results of the first 100 consecutive renal transplants performed at Barnes Hospital and the Veterans Administration Hospital in St. Louis between 1963-1973 are shown in Figs. 4, 5 and 6. Patients comprising this group include both good and bad risk cases, both those done in the early "investigative" stages as well as the recent transplants, all age groups and all second transplants. Thus, no favorable bias is introduced in analyzing these results. The overall kidney function rate at two years was 43% for the 100 cases studied. In the 68 nonrelated donor grafts, 32% were successfully functioning at two years. In the 32 related donor grafts, 64% continued to function after two years. No kidneys were lost after two years in either the related or unrelated group. The most precipitous drop in kidney function rate occurred in the first three months after transplantation.

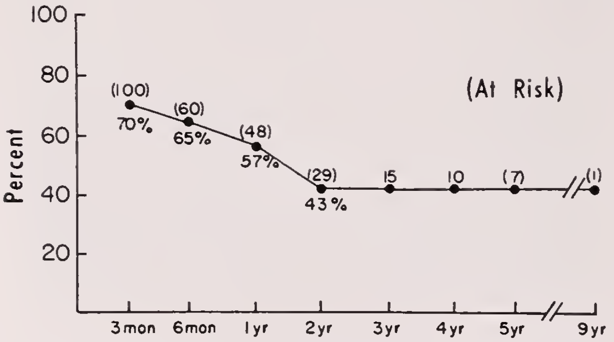

Fig. 4 Duration of renal transplant function in 100 related and nonrelated donor grafts. (VA and Barnes. 1963-1973)

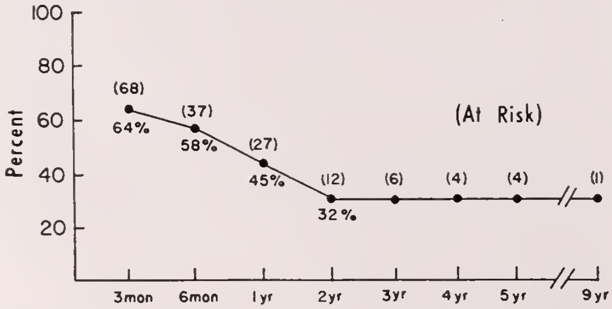

Fig. 5. Duration of renal transplant function in 68 nonrelated donor grafts. (VA and Barnes. 1963-1973)

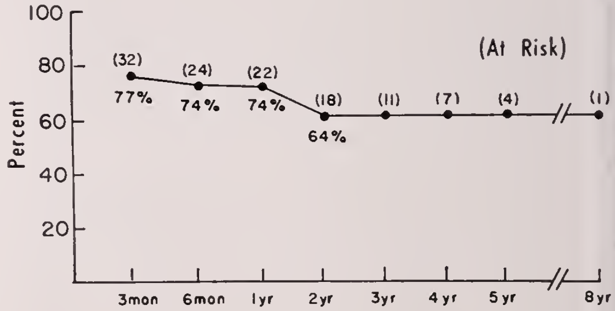

Fig. 6 Duration of renal transplant function in 32 related donor grafts. (VA and Barnes. 1963-1973)

Summary

Renal transplantation has become an effective and established means of treating end stage renal disease. The transplant registry report indicates that in transplants performed over the past five years, successful kidney function at two years is observed in 70% to 80% of living related-donor transplants and in 45% to 50% of cadaver transplants. For the past five years, there has been no significant improvement in kidney survival rates despite a variety of changes in immunosuppressive regimens. Areas of investigation which could possibly improve results include the use of ALG, better tissue typing and matching, the prevention of sensitization and the application of methods to induce tolerance or enhancement. Sufficient experience with and facilities for renal transplantation now exist in Missouri to provide this service to the increased number of patients who will require and demand it.

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Platelet Transfusion

(Continued from page 232)

B. *Relative Contraindications*

1. Disseminated intravascular coagulation.
2. Immune thrombocytopenic purpuras.
3. Diminished platelet function due to medications (take away the medicine first).
4. Modest thrombocytopenia (greater than 20,000/mm^3) in patients who are not bleeding.
5. Thrombocytopenia of unknown pathophysiology.
6. Previously demonstrated refractoriness to platelet transfusions in patients who are not actually bleeding. These patients may, however, still respond well to HL-A matched platelet transfusions.

Summary

Platelet transfusions are useful to stop or prevent bleeding caused by thrombocytopenia or platelet dysfunction in situations in which the process is anticipated to be temporary and platelets are not being destroyed at an increased rate.

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Traumatic Shock Monitored by Doppler Ultrasonic Flowmeter

Case Report

IN THIS AGE of mechanization and technical advancement, we have noted an increase in multiple injuries. High speed crashes demolish not only the machines involved but, also, the persons in them. Survival has been enhanced by the use of seat belts and shoulder straps, but multiple traumata in the emergency room are still on the rise. After arrival in the emergency room, the victim of multiple traumata is the focus of much activity. Intravenous cannula must be inserted so that fluids and blood which have been lost may be replaced. Pulse and respiration are monitored and an airway for the patient to breathe must be maintained. A subclavian catheter may be used for intravenous fluids and central venous pressure determinations. The patient's condition must be stabilized, if possible, before more heroic activity takes place.

One of the items essential to monitor is blood pressure. Many times because of the activity occurring or because of the extent of injuries to the patient it is a veritable impossibility to obtain a valid blood pressure. Arterial cannulation, pressure transducers and read-out machines are not always available in the emergency room, the operating room, the recovery room or surgical intensive care unit. When such equipment is available, there always seems to be a lack of personnel acquainted with the use of the aforementioned equipment. In the smaller hospital where the above equipment is not in regular usage, a state of utter consternation may ensue when the patient with multiple injuries and involvement of the upper extremities is admitted.

It is our intent in this short article to present by case report a simple means of obtaining systolic blood pressure by indirect means utilizing the Doppler ultrasonic flowmeter and a blood pressure cuff.

This case report of multiple injuries is used to demonstrate a simple means of monitoring blood flow and pressure indirectly and inexpensively when hypovolemia and multiple traumata cause consternation in the emergency room. The authors are from the Department of Surgery, University of Missouri School of Medicine.

CASE REPORT

A young white man, who had been involved in an automobile wreck, was admitted to the emergency room in shock, suffering from multiple traumata involving both upper extremities. Respiration was shallow and rapid, and it was determined that the patient had suffered a pneumothorax. Nasotracheal intubation and positive respiratory control was established. Ches tubes were placed with negative pressure. A Levi tube was passed into the stomach. A subclavian catheter was placed for fluid replacement and determinatio of central venous pressure (Fig. 1).

Blood pressure was ascertained by indirect mean utilizing a blood pressure cuff placed at the ankle an a Doppler ultrasonic flowmeter to determine return o flow after release of the occlusive cuff. It has been reported that the ankle pressure thus obtained is equa to the arm pressure ±10 mm Hg.[1] In Fig. 2, the patient's blood pressure is being taken in the surgical intensive care unit. The nurse is using the posterior tibia artery to ascertain return of bloodflow after the occlusive cuff is released. If the posterior tibial is not present, the dorsalis pedis may be used for this purpose. I this particular case it was possible to use either ankl since the lower limbs had not sustained appreciabl trauma.

The Doppler ultrasonic flowmeter has been use in burn cases in which the upper extremity burn make it impossible to utilize a pressure cuff on th arm. (It also is used to monitor, indirectly, bloo pressure in the arm of a malignantly obese patien in the 600 lb range.)

METHODS

The Doppler ultrasonic flowmeter is an electron

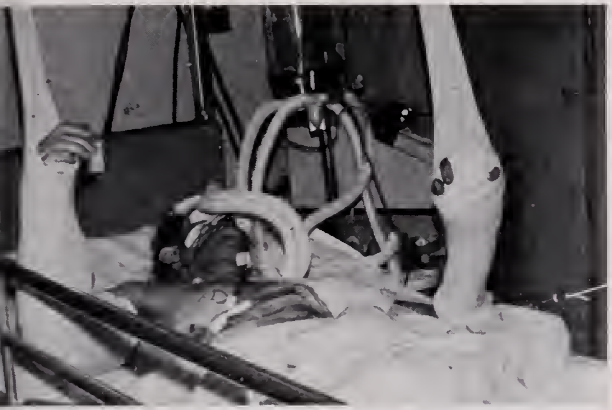

Fig. 1 Traumatized patient requiring indirect means of monitoring blood pressure.

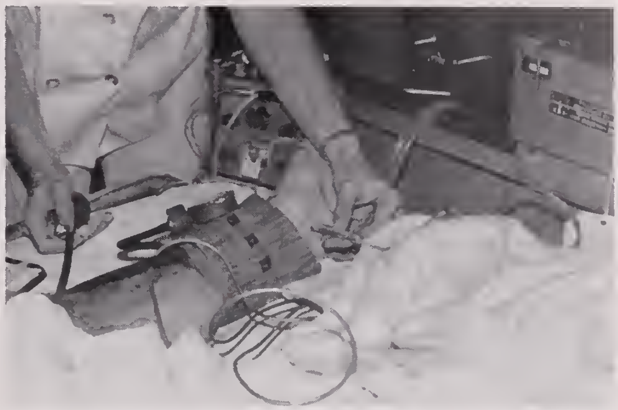

Fig. 2 Use of the Doppler ultrasonic flowmeter in the Surgical Intensive Care Unit to indirectly monitor blood pressure.

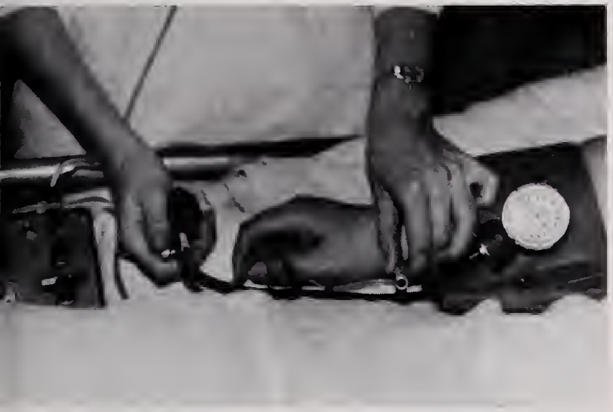

Fig. 3 Using the blood pressure cuff in the forearm position to determine systolic blood pressure with the Doppler instrument and the radial artery.

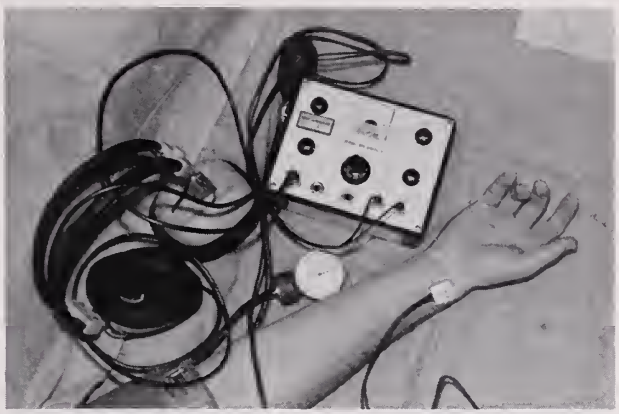

Fig. 4 Use of the Doppler ultrasonic flowmeter in the emergency room for continuous indirect systolic pressure monitoring.

ic device with which arterial blood flow in tissue may be detected transcutaneously without danger of already compromised vascularity or appendages being further compromised. The Doppler ultrasonic flowmeter operates on a modification of the principle first described by Christian Djohann Doppler, a 19th century, Austrian physicist and mathematician. The Doppler effect has to do with changes in the pitch of sound as the distance between the source and the listener are rapidly varied.

The ultrasonic flowmeter consists of an oscillator, a probe containing two piezoelectric crystals of identical natural resonating characteristics, an amplifier to amplify the frequency difference (f_d) when the output of one crystal is reflected from a red blood cell and received by the second crystal at a slightly different frequency and a means of presenting an audio or video signal.

By utilizing a blood pressure cuff about the ankle (Fig. 2) and listening for the return of flow after the occlusive cuff has been released, the systolic pressure of the ankle is obtained and has been demonstrated to be within ± 10 mm Hg in the normal patient, i.e., those without significant peripheral vascular occlusive disease.[1] In Fig. 3, it is shown that blood pressures may be obtained from the forearm of a patient with upper arm damage. The flowmeter may be used to determine the extent of vascular injury as well as being an adjuvant in the determination of systolic blood pressure.[2] Studies have shown that there is usually less than 5 mm Hg difference between pressures taken with the cuff in normal arm position and that noted in the forearm using either the Doppler ultrasonic flowmeter or digital plethysmography.[3] Fig. 4 shows the use of the Doppler instrument with a flat probe which may be used for continual indirect monitoring of blood pressure, a procedure utilized as a back-up during open-heart operations and during anesthesia.[4, 5]

(Continued on page 243)

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Pulmonary Infiltrates in Lymphoma: Value of Bronchial Brushing

Case Reports

A DIAGNOSTIC PROBLEM is often posed by the development of a pulmonary parenchymal infiltrate in a patient with known Hodgkin's disease or lymphoma. Infection, often with opportunistic organisms, parenchymal lymphoma, radiation pneumonia and unrelated disease processes, may all occur in these patients.

Bronchial brushing is a safe[1] and easy diagnostic procedure used for the cytologic diagnosis of lung cancer.[2, 3] Its usefulness in the diagnosis of pulmonary infections,[3] metastatic disease,[4] and to determine the etiology of lung cavities[5] also has been described. This paper will demonstrate the value of bronchial brushing in patients with Hodgkin's disease or other lymphomas who have undiagnosed pulmonary lesions.

Several authors have described the cytologic diagnosis of Hodgkin's disease and malignant lymphoma involving the lung parenchyma.[6, 7] It is logical to make use of bronchial brushing to obtain necessary cytologic material since this method allows the recovery of endobronchial specimens from localized areas of disease. During the past 18 months, we have performed bronchial brushing via a transcricothyroid membrane approach using a modified Seldinger technique[8] on six patients with Hodgkin's disease and on one patient with lymphocytic lymphoma, all of whom have undiagnosed pulmonary parenchymal disease. The results are summarized in Table 1.

CASE REPORTS

Case # 1. A 29-year-old man was found to have mediastinal nodular sclerosing Hodgkin's disease diagnosed by thoracotomy in 1966. Radiation therapy was given during this initial admission and, also, on severa subsequent occasions for recurrent disease in various locations. In April, 1971, evidence of widespread disease was present and included bilateral pleural effusions, hepatosplenomegaly and massively enlarged retroperitoneal lymph nodes. Since that time, various courses of chemotherapy were tried with several remissions and exacerbations. In November, 1972, he devel oped fever, chills and progressive malaise with a ches radiograph showing multiple bilateral pulmonary infil trates (Fig. 1). Examination of the sputum, including cytology, was unremarkable. No evidence of lung in fection was demonstrated. Cytologic examination o

TABLE 1

Patient	*Age*	*Sex*	*Previous Diagnosis*	*Radiographic Abnormality*	*Brushing Cytology*	*Final Diagnosis of Lung Disease*	*How Made or Confirmed*
#1	30	M	Hodgkin's, nodular sclerosing	Diffuse infiltrates	Hodgkin's	Hodgkin's	Brush
#2	20	F	Hodgkin's, mixed cellularity	RLL infiltrate, RML nodule	Negative	Hodgkin's	Surgery
#3	27	M	Hodgkin's, nodular sclerosing	RML & RLL infiltrate, rt. pleural effusion	Negative	Hodgkin's	Response to chemotherapy
#4	47	F	None made	LUL atelectasis	"Suspicious"	Hodgkin's, nodular sclerosing	Surgery
#5	41	F	Hodgkin's, not classified	Diffuse infiltrates	Negative	Hodgkin's, radiation pneumonia, lipoid pneumonia	Autopsy
#6	25	M	Hodgkin's, nodular sclerosing	RLL cavitary density	Hodgkin's	Hodgkin's	Brush and surger
#7	59	M	Lymphocytic lymphoma	Lingular density	Cancer	Adenocarcinoma of the lung	Brush and surger

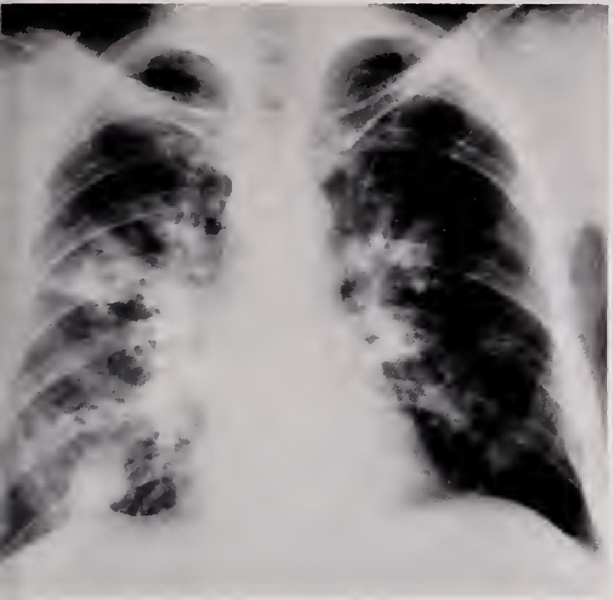

Fig. 1 Case #1. A PA chest radiograph showing diffuse umonary infiltrates diagnosed by bronchial brushing as ulmonary Hodgkin's Disease.

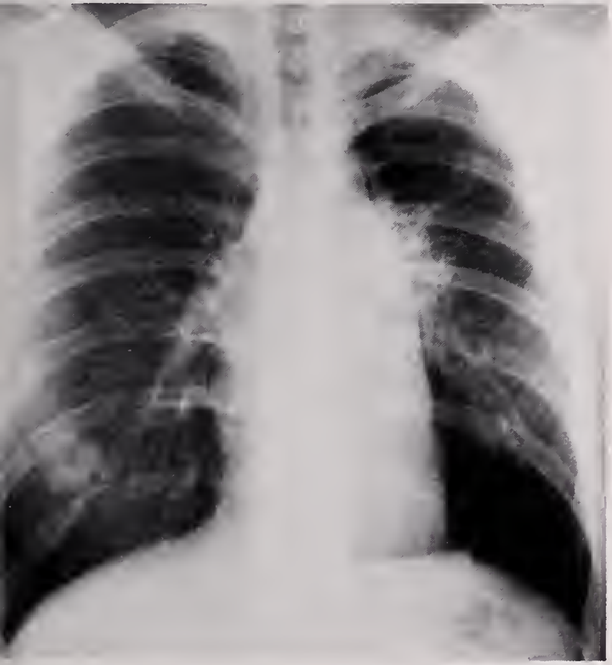

Fig. 3 Case #6. A PA chest radiograph showing radiaion change in the left upper lobe and a cavitary right lowr lobe density shown to be pulmonary Hodgkin's disease y bronchial brushing and subsequent surgery.

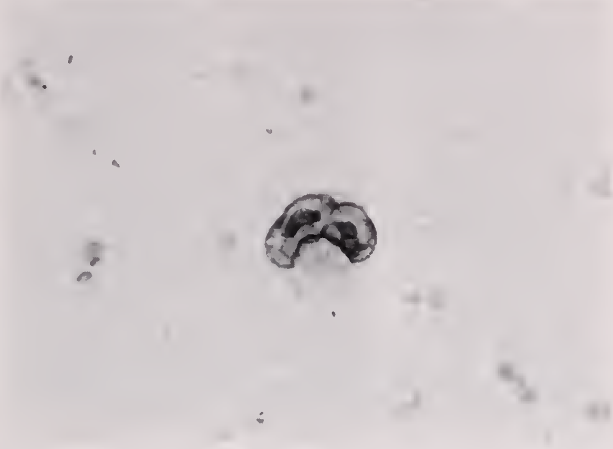

Fig. 2 Case #1. Cytologic smear from bronchial brushing specimen showing a Reed-Sternberg cell. (Papanicolaou stain × 720).

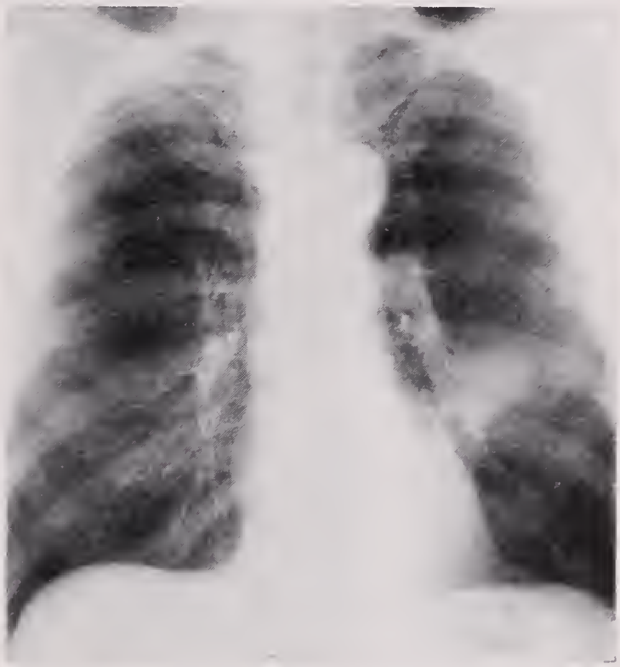

Fig. 4 Case #7. A PA chest roentgenograph shows a poorly defined lingular density in a patient with lymphocytic lymphoma. This was shown to be due to adenocarcinoma of the lung by bronchial brushing and subsequent surgery.

ronchial brushing specimen showed Hodgkin's disease Fig. 2).

Case # 6. This patient was a 25-year-old man with odular sclerosing Hodgkin's disease diagnosed in pril, 1972, on a biopsy of enlarged cervical lymph odes. A course of radiation therapy to the neck, medistinum and left lung was carried out. In June, 1972, e developed radiation pneumonia in the left upper lobe. Chemotherapy with cytoxan, oncovin, procarbazine and prednisone was begun in August, 1972. In January, 1973, a cough with blood streaked sputum developed. A chest film showed a right lower lobe cavitary density (Fig. 3). Evaluation, including bronchoscopy, was negative, but bronchial brushing cytology revealed Hodgkin's disease. Because of the development of pulmonary Hodgkin's disease while the patient was receiving chemotherapy, a right lower lobectomy was performed which confirmed the diagnosis.

Case # 7. A 59-year-old man was discovered to have well differentiated lymphocytic lymphoma in April, 1970, on biopsy of enlarged inguinal lymph nodes. Radiation therapy was given. He remained asymptomatic

Bronchial brushing was performed on six patients with Hodgkin's disease and one patient with lymphocytic lymphoma and pulmonary parenchymal disease. Parenchymal Hodgkin's disease was documented cytologically in two of these patients. Adenocarcinoma of the lung was revealed in another. Bronchial brushing is a well-proven, safe diagnostic method which can be used to determine the etiology of parenchymal lung disease in patients with Hodgkin's disease and lymphoma. The authors are from The Mallinckrodt Institute of Radiology, Washington University School of Medicine.

until October, 1971, when a chest radiograph showed interval development of a poorly defined lingular density (Fig. 4). The presumptive diagnosis was pulmonary parenchymal lymphoma. Bronchoscopy, sputum cytology and routine work-up were unremarkable and the patient had a bronchial brushing which allowed a cytologic diagnosis of lung cancer. A left upper lobectomy confirmed the diagnosis of adenocarcinoma of the lung.

DISCUSSION

Although the radiographic picture may be characteristic of pulmonary Hodgkin's disease if mediastinal disease spreads by direct extension into the adjacent lung, often the roentgenogram is nonspecific. Areas of pulmonary consolidation or nodular densities are usually indistinguishable from infection or other neoplasms.

With the use of more effective chemotherapy, patients with lymphoma survive longer, but often develop pulmonary infection, which may be due to a wide variety of bizarre opportunistic organisms. Specific microbiologic diagnosis usually must be rapidly obtained to avoid morbidity and mortality. Aspergillus and pneumocystis carinii are particularly common pathogens in this group. The use of bronchial brushing to recover these organisms has been the subject of recent reports.[6, 9] Although our series does not include any infectious processes, we have utilized bronchial brushing successfully to diagnose opportunistic infection in other immunosuppressed patients.

In patients # 1, # 2, # 3, # 5 and # 6 (Table 1), the possibility of infectious disease as the cause of the roentgenographically demonstrable pulmonary infiltrates was strongly considered. Bronchial brushing was performed primarily to exclude this possibility. None of these brushings revealed infection, but a cytologic diagnosis of pulmonary parenchymal Hodgkin's disease was achieved in two patients (Figs. 1 & 3). Four other patients (# 2-# 5) whose brushing cytology did not show Hodgkin's disease were later diagnosed as pulmonary Hodgkin's disease by other methods.

Secondary pulmonary parenchymal Hodgkin's disease occurs in 27% to 40% of cases, while other lymphomas involve the lung in from 3% to 25% of cases.[6, 10, 11] Two problems exist in diagnosing pulmonary lymphoma cytologically: accurate classification of pathologic cells and recovery of abnormal cells for study.

An absolute cytologic diagnosis of pulmonary lymphoma is virtually impossible.[7] Even the recovery of Reed-Sternberg cells is not sufficient evidence for the diagnosis of Hodgkin's disease, sinc such cells have been reported in other conditions.[12] The finding of individual tumor cells with characteristic nuclear features occurring in the absenc of cell clusters allows a presumptive diagnosis of Hodgkin's disease in the appropriate clinical setting.[6] Cell block preparations rather than smears may aid in the cytologic diagnosis of pulmonary Hodgkin's disease.[13] In lymphoma other than Hodgkin's disease, the finding of small, undifferentiated tumor cells may be confused with oat cel carcinoma.[14, 15] The occasional occurrence of othe neoplasms in the lung in patients with lymphom (Fig. 4) adds to this problem.[6]

Obtaining good cytologic specimens from patients with pulmonary lymphoma may be just a difficult as making the correct cytologic interpretation. In patients with massive pulmonary involvement, there is often direct invasion and focal destruction of the bronchial tree. In these cases tumor cells may be readily recovered from routin sputum specimens.[6] Usually, however, pulmonar lymphomas involve secondary bronchi and dista bronchioles rather than the main bronchi.[16] Collections of tumor cells may also be located beneat the intact epithelium of larger bronchi.[11] This results in a low incidence of positive cytologic examinations of sputum or bronchial washings i this disease.

The abrasive action of bronchial brushing ma extend the cytologic diagnosis of pulmonary lymphoma when routine sputum examinations are negative by allowing retrieval of material from beneath the intact respiratory epithelium and fro the distal bronchioles. Previously, cytologic smea obtained by brushing were reported as not bein helpful, although tissue fragments obtained wit a forceps mechanism positioned through a bro chial catheter were diagnostic.[17] In our series, we found that the smears obtained from the less hazardous routine brushing technique to be of value.

While radiation pneumonia and fibrosis are sometimes seen in patients with Hodgkin's disease and lymphoma, these entities usually are easily diagnosed by correlation with radiation ports, their characteristic time of evolution and, often, typical radiographic appearance. Bronchial brushing is not effective in diagnosing this condition, and, if necessary, a lung biopsy would be necessary to confirm the diagnosis.

Acknowledgement: The cytologic criteria and review of the cytologic specimens were done by Dr. Michael Kyriakos, Department of Pathology, Washington University School of Medicine.

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Traumatic Shock

(Continued from page 239)

Discussion

The Doppler ultrasonic flowmeter has been in use in the University of Missouri Medical Center for a period of more than five years. It is used as an adjunct to angiography and in cases of severe trauma or in cases of embolization, as a primary diagnostic tool in the emergency room. Emboli in the lower or upper extremity can be detected with the instrument as can thrombi in the deep or superficial venous systems.[6] Localization of embolus or thrombus enhances the success rate of an embolectomy or thrombectomy.

Use of the ultrasonic flowmeter to indirectly monitor blood pressure has been documented by the author and others.[7, 8] We have attempted to present the use of the instrument in the emergency setting when no other means of obtaining data is available. Use of the Doppler instrument is completely atraumatic and does not carry the stigma of morbidity or mortality of angiography or both.

Summary

The Doppler ultrasonic flowmeter, when used as described herein, is a valuable adjunct to the armamentarium of the physician and surgeon. The instrument may be used to indirectly monitor systolic blood pressure, atraumatically in either the arm or in the leg if one has been traumatized. Several instruments are marketed and the ones mentioned are relatively inexpensive, battery operated, portable and extremely reliable.

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Prevalence of Polio and Measles Antibodies Among Preschool Children

The United States Immunization Survey, 1971,[1] noted that only 67% of children one to four years of age had received adequate immunization against poliomyelitis. More significantly, only 54% of such children in poverty areas of large metropolitan cities were adequately immunized. Similarly, poor immunization histories exist for measles; 49% of urban poverty area children one to four years of age had received measles vaccine. Even in nonpoverty urban areas, the percentage was only 62%.[1]

The present study was undertaken to determine polio and measles antibody prevalence among suburban and center city preschool children in Kansas City, Mo. and to compare this prevalence with that determined by the U. S. Immunization Survey and other serologic surveys.

Methods

Study Population. Seven of the larger preschools in Kansas City were selected, based on their geographic location within the metropolitan area. The schools included three that serve a suburban population and four that serve a lower-socioeconomic center-city population. All schools are subject to the State Health Department code which requires immunization against polio, diphtheria, tetanus and smallpox, but this requirement may be waived at the discretion of the school director or the child's physician. Explanatory letters and informed consent sheets with a vaccine history questionnaire were sent home with each of the 355 children at the seven schools.

Serum Samples. Venipunctures were performed at the various day schools in March, 1972 by two teams of two physicians and one nurse. All sera were separated aseptically and stored at –20 C until tested.

Antibody Determinations. Specific neutralizing antibodies to poliovirus types 1, 2 and 3 were determined by the microtiter technique[2] using LLC-MK_2, a continuous rhesus monkey kidney cell line Measles hemagglutination inhibition (HI) antibodies were determined by a microtiter technique using African green monkey erythrocytes.

Appropriate vaccines were offered to all childre who lacked detectable antibodies to any polioviru type or to measles virus.

Results

Study Population. Center-city parents gave permission for obtaining blood samples more readil than did suburban parents (46% versus 37%). Sixty one serum samples from suburban children and 6 samples from center-city children were obtaine for antibody testing. Serum from three childre was insufficient to complete measles antibody titrations.

The majority of the children (67%) were thre or four years of age. The remainder were fiv (28%) or six (5%) years old. There were an equa

---

A serologic survey taken to determine poliovirus and measles antibody prevalences in preschool children in Kansas City, Mo. shows that they appear to be adequate to prevent epidemic poliomyelitis, but are inadequate to prevent epidemic measles.

This paper is from the Virus Disease Section, Kansas City Laboratories, Ecological Investigations Program (EIP), Center for Disease Control (CDC), Health Services and Mental Health Administration, Public Health Service, U. S. Department of Health, Education and Welfare, Kansas City, Kan. Dr. Rousseau and Dr. Jordan are Epidemic Intelligence officers, Epidemiology Division, CDC, Atlanta, Ga. assigned to Kansas City Laboratories, EIP. Dr. Tegtmeier is Chief, Serology Unit, and Dr. Noble is Chief, Virus Disease Section, Kansas City Laboratories, EIP. Dr. Chin is Director, Kansas City Laboratories, EIP.

TABLE 1

ILLNESS AND IMMUNIZATION HISTORIES OF DAY SCHOOL CHILDREN IN SUBURBAN AND CENTER CITY AREAS, KANSAS CITY, MO., MARCH, 1972

	Poliovirus		*Measles*		
Area	HISTORY OF ANY VACCINATION	HISTORY OF ADEQUATE VACCINATION*	HISTORY OF ILLNESS	HISTORY OF VACCINATION	HISTORY OF ILLNESS OR VACCINATION
burban N = 61	52 (85%)‡	32 (52%)	2 (3%)	45 (74%)	47 (77%)
enter City N = 65	62 (95%)	35 (54%)	11 (17%)	48 (74%)	54 (83%)
otal N = 126	114 (90%)	67 (53%)	13 (10%)	93 (74%)	101 (80%)

* ≥ three doses of oral poliovirus vaccine.
‡ Number of children (percent).

mber of boys and girls.

Immunization History. Immunization question-ires revealed that although 114 (90%) children d received at least one dose of oral poliovirus ccine (OPV), only 67 (53%) had received ade-ate polio immunization, i.e., ≥ three doses of PV (Table 1). There was no significant differ-ce between suburban and center-city children re-rding the number who were adequately immu-zed.

The suburban schools and the center-city schools d equal percentages (74%) of children with mea-s vaccination history (Table 1). Eleven (17%) ildren in the center city had a history of illness mpared with two (3%) suburban children. Based history of illness or of immunization, 20% of e study population were susceptible to measles. ere was no significant difference between sub-ban and center-city areas.

Antibody Determinations. Table 2 shows the evalence of type-specific poliovirus neutralizing antibodies among the children.

Ninety-eight percent of all children had antibodies (serum titer ≥ 1:8) to poliovirus type 2. Fewer children had antibodies to type 1 (79%) and to type 3 (75%). There were no significant differences between suburban and center-city study groups in the prevalence of antibodies to any of the three poliovirus types measured at levels of either ≥ 1:4 or ≥ 1:8. Forty-six (37%) children had antibody titers of less than 1:8 to one or more types of polioviruses, making them potentially suceptible to poliomyelitis.

The distribution of serum HI antibodies against measles virus is shown in Table 3. The overall prevalence of measles antibodies (serum titer ≥ 1:10) was 79%. There was no significant difference between suburban (78%) and center-city (80%) children.

COMMENT

Declining immunity rates, especially among the

TABLE 2

PREVALENCE OF POLIOVIRUS NEUTRALIZING ANTIBODIES* AMONG DAY SCHOOL CHILDREN IN SUBURBAN AND CENTER CITY AREAS, KANSAS CITY, MO., MARCH, 1972

	Poliovirus Type 1		*Poliovirus Type 2*		*Poliovirus Type 3*	
Area	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT
burban N = 61	48	79	59	97	46	75
nter City N = 65	51	78	64	98	48	74
tal N = 126	99	79	123	98	94	75

* Serum neutralizing antibody titer ≥ 1:8.

TABLE 3
DISTRIBUTION OF MEASLES HEMAGGLUTINATION INHIBITION ANTIBODIES AMONG DAY SCHOOL CHILDREN IN SUBURBAN AND CENTER CITY AREAS, KANSAS CITY, MO., MARCH, 1972

Area	*Titer $< 1:10$*		*Titer $\geqslant 1:10$*	
	NUMBER	PERCENT	NUMBER	PERCENT
Suburban N = 58	13	22	45	78
Center City N = 65	13	20	52	80
	—	—	—	—
Total N = 123	26	21	97	79

urban poor, have been documented by the U. S. Immunization Survey[1] and have received frequent comment.[4, 5] The initially enthusiastic response to poliovirus vaccine had made poliomyelitis an increasingly rare clinical disease, with only 17 cases reported in the United States in 1971.[6] However, the case reported by Lamb and Feldman[7] and the recent epidemic in Greenwich, Conn.[8, 9] point out the continuing threat of poliomyelitis among unimmunized individuals.

This study and the 1971 Immunization Survey found that only 53% to 54% of preschool children have a history of adequate immunization against poliomyelitis. This is similar to the 56% figure obtained by Poland and colleagues[10] in the Kansas City survey in 1966. However, we were unable to show any differences by immunization history between the center city and suburban populations studied. This lack of differences may have been due to the nonrandom character and select nature of our study population, since we studied only children attending preschools whose parents gave permission for the investigation.

Our study indicated that 37% of the children are potentially susceptible to one or more of the three poliovirus serotypes. The antibody levels of 79% for type 1, 98% for type 2 and 75% for type 3 are similar to those observed by Poland *et al*[10] in a 1966 serologic survey in Kansas City, and only slightly higher than those reported by Lamb and Feldman[11] in the 1970 Syracuse study. The recent report of Gold *et al*,[12] however, showed a comparatively lower prevalence of antibody in Cleveland than in Kansas City. Kansas City has not experienced an epidemic of poliomyelitis since 1959 when 259 cases were reported. The last reported case occurred in 1964. It appears, therefore, that immunity against the polioviruses has been sufficient to prevent epidemic poliomyelitis, althoug
this immunity may not have been challenged b
the introduction of wild viruses.

Measles control, like polio control, was characterized by an initial surge of interest in vaccinatio
with a consequent dramatic fall in the number o
cases. Reported measles cases declined from nearl
500,000 annually before vaccine became availabl
in 1963 to only 22,000 in 1968.[13] However, measle
immunizations have declined recently,[1] leading t
an increase in reported cases which totaled 40,00
in 1970 and 75,000 in 1971.[13] Kansas City likewis
experienced a fall in reported measles cases to 25
in 1968 followed by progressive rises to a peak o
1,407 cases in 1971.

Our survey revealed that 74% of selected preschool children three to six years of age in Kansa
City had received measles vaccine. This numbe
was higher than that found by the Immunizatio
Survey in central cities[1] and probably reflected th
select character of our study group. However, 21
of our children lacked detectable antibodies t
measles and were potentially susceptible to measle
infection. This 79% "immunity level" was lowe
than that found by Lamb and Feldman in thei
1970 survey[11] and was a level inadequate to preven
epidemic measles.[14]

Serologic surveys such as this provide a data bas
for local and national immunization program
Immunization questionnaire surveys also appea
to be a useful measure of immunization practic
as evidenced by the reasonable correlation betwee
immunization history and serum antibody prevalence in this study. The "immunity gap" whic
Melnick *et al*[15] noted must be recognized, and vigorous community education and immunizatio
programs must be implemented to close this gap.

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Continuing Education Coming Events

May 12	**Citywide Radiology Conference: Evaluation of Genitourinary Disease** Mallinckrodt Institute of Radiology, St. Louis
May 20	**Upper Respiratory Infections in Children** N.W. Mo. Chapter, Missouri Academy of Family Physicians and K.U. School of Medicine Moila Temple, St. Joseph
May 29	**Conference: The Risk of Cytomegalovirus Infection Transmitted by Blood Transfusion** Community Blood Center of Greater Kansas City Plaza Inn, Kansas City
June 4	**Seminar: Acute and Chronic Respiratory Failure** Ed Bixby Institute for Postgraduate Medical Education Research Hospital and Medical Center, Kansas City
June 4	**Recent Advances in Perinatal Medicine** Continuing Medical Education Washington U. School of Medicine, St. Louis
June 5-7	**Symposium: Clinical Care** M.U.-Kansas City School of Medicine Crown Center Hotel, Kansas City
June 6-7	**Eighth Annual Professional Meeting** Missouri Chapter, American College of Surgeons Sheraton-West Port Inn, St. Louis
June 14	**Recent Advances in Management of Cancer** Continuing Medical Education Washington U. School of Medicine, St. Louis
June 21	**Semiannual Professional Program: Recent Advances in Medical Oncology** Ellis Fischel State Cancer Hospital and Cancer Research Center Ramada Inn, Columbia

MSMA Woman's Auxiliary Elects Mrs. William R. McPhee

Mrs. William R. McPhee, Kansas City, was elected President of the MSMA Woman's Auxiliary at the annual convention held in conjunction with the MSMA Annual Session at the Chase-Park Plaza Hotel in St. Louis on April 17-20.

Other Auxiliary officers elected for 1975-1976 are Mrs. George P. Wilson, Columbia, President-Elect; Mrs. Sam Gaston, Joplin, First Vice-President; Mrs. W. Jack Stelmach, Kansas City, Second Vice-President; Mrs. Donald Fakhoury, Kansas City, Third Vice-President; Mrs. R. W. Hartwig, Kansas City, Fourth Vice-President; Mrs. Harry E. Raybuck, St. Louis, Recording Secretary; Mrs. F. T. H'Doubler, Springfield, Treasurer; Mrs. E. E. King, III, Normandy, Auditor; Mrs. C. E. Workman, Kansas City, Corresponding Secretary; and Mrs. W. H. Hickerson, Independence, Parliamentarian.

Mrs. McPhee is a Past-President of the Clay County Medical Auxiliary and is a founding member and served as charter president of the North Kansas City Memorial Hospital Auxiliary.

Active in civic affairs, she is a member of the Sister City Commission of Kansas City, a founding member of Northland Meals on Wheels, Inc. and a board member of the Voluntary Action Center of the Kansas City Metropolitan Region.

Her participation in other community affairs includes service as a leader in both the Girl and Boy Scouts, the Jackson County Child Welfare Advisory Committee, The Hale Cook PTA and the Parents and Children's Task Force. She is now a member of the Steering Committee for the Task Force on Child Abuse in Kansas City.

Mrs. McPhee is a graduate of the University of Kansas in Lawrence and holds a bachelor of science degree in education with an English major and minors in history and psychology. From 1949 to 1951, she taught the third grade at Parker School in Kansas City, Kan.

Dr. and Mrs. McPhee are the parents of two children. Mark Steven is now a medical student at the University of Kansas School of Medicine. Their daughter, Martha Ann, is a pre-law student at Yale University.

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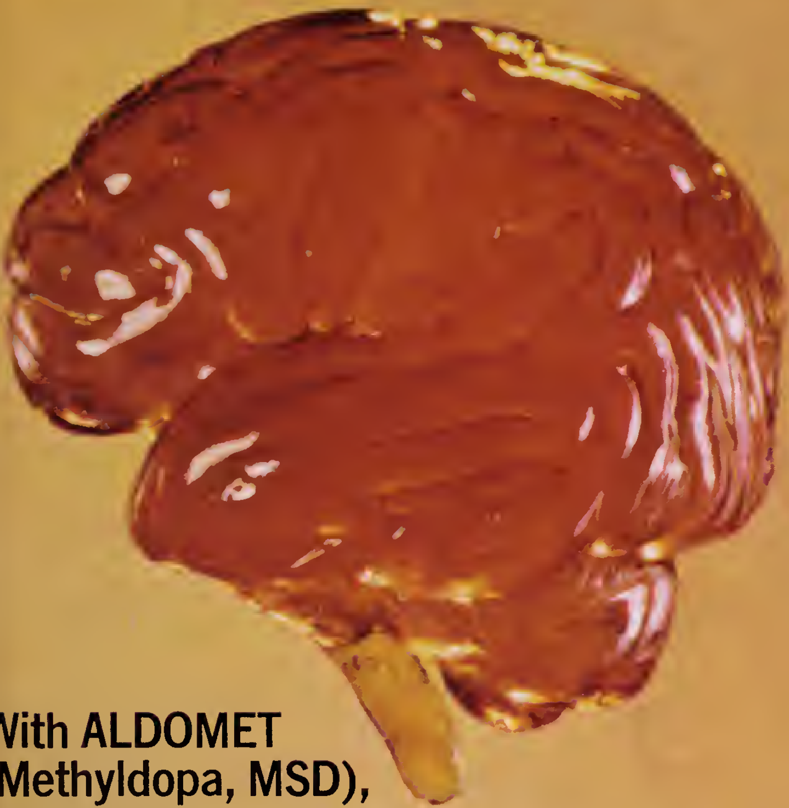

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Warnings: It is important to recognize that a positive Coombs test, hemolytic anemia, and liver disorders may occur with methyldopa therapy. The rare occurrences of hemolytic anemia or liver disorders could lead to potentially fatal complications unless properly recognized and managed. Read this section carefully to understand these reactions.

With prolonged methyldopa therapy, 10% to 20% of patients develop a positive direct Coombs test, usually between six and twelve months of therapy. Lowest incidence is at daily dosage of 1 g or less. This on rare occasions may be associated with hemolytic anemia, which could lead to potentially fatal complications. One cannot predict which patients with a positive direct Coombs test may develop hemolytic anemia. Prior existence or development of a positive direct Coombs test is not in itself a contraindication to use of methyldopa. If a positive Coombs test develops during methyldopa therapy, determine whether hemolytic anemia exists and whether the positive Coombs test may be a problem. For example, in addition to a positive direct Coombs test there is less often a positive indirect Coombs test which may interfere with cross matching of blood.

At the start of methyldopa therapy, it is desirable to do a blood count (hematocrit, hemoglobin, or red cell count) for a baseline or to establish whether there is anemia. Periodic blood counts should be done during therapy to detect hemolytic anemia. It may be useful to do a direct Coombs test before therapy and at six and twelve months after the start of therapy. If Coombs-positive hemolytic anemia occurs, the cause may be methyldopa and the drug should be discontinued. Usually the anemia remits promptly. If not, corticosteroids may be given and other causes of anemia should be considered. If the hemolytic anemia is related to methyldopa, the drug should not be reinstituted. When methyldopa causes Coombs positivity alone or with hemolytic anemia, the red cell is usually coated with gamma globulin of the IgG (gamma G) class only. The positive Coombs test may not revert to normal until weeks to months after methyldopa is stopped.

Should the need for transfusion arise in a patient receiving methyldopa, both a direct and an indirect Coombs test should be performed on his blood. In the absence of hemolytic anemia, usually only the direct Coombs test will be positive. A positive direct Coombs test alone will not interfere with typing or cross matching. If the indirect Coombs test is also positive, problems may arise in the major cross match and the assistance of a hematologist or transfusion expert will be needed.

Fever has occurred within first three weeks of therapy, sometimes with eosinophilia or abnormalities in liver function tests, such as serum alkaline phosphatase, serum transaminases (SGOT, SGPT), bilirubin, cephalin cholesterol flocculation, prothrombin time, and bromsulphalein retention. Jaundice, with or without fever, may occur, with onset usually in the first two to three months of therapy. In some patients the findings are consistent with those of cholestasis. Rarely fatal hepatic necrosis has been reported. These hepatic changes may represent hypersensitivity reactions; periodic determination of hepatic function should be done particularly during the first six to twelve weeks of therapy or whenever an unexplained fever occurs. If fever, abnormalities in liver function tests, or jaundice appear, stop therapy with methyldopa. If caused by methyldopa, the temperature and abnormalities in liver function characteristically have reverted to normal when the drug was discontinued. Methyldopa should not be reinstituted in such patients.

Rarely, reversible reduction in leukocyte count with primary effect on granulocytes has been seen. Reversible thrombocytopenia has occurred rarely. When used with other antihypertensive drugs, potentiation of antihypertensive effect may occur.

Use in Pregnancy and Childbearing Age—Not recommended in pregnancy. In women of childbearing age, weigh potential benefits against possible fetal hazards.

Precautions: Methyldopa may interfere with measurement of: uric acid by the phosphotungstate method, creatinine by the alkaline picrate method, and SGOT by colorimetric methods. Since methyldopa causes fluorescence in urine samples at the same wavelengths as catecholamines, spuriously high levels of urinary catecholamines may be reported. This will interfere with the diagnosis of pheochromocytoma. Stop drug if involuntary choreoathetotic movements occur in patients with severe bilateral cerebrovascular disease. Patients may require reduced doses of anesthetics; hypotension occurring during anesthesia usually can be controlled with vasopressors. Hypertension has occurred after dialysis in patients on methyldopa because the drug is removed by this procedure.

Adverse Reactions: Sedation, usually transient, may be seen during initial therapy or when dosage is increased. Headache, asthenia, or weakness may be noted as early, transient symptoms. Symptoms associated with effective lowering of blood pressure are occasionally seen and include dizziness, lightheadedness, and symptoms of cerebrovascular insufficiency. Angina pectoris may be aggravated. Symptoms of orthostatic hypotension may occur; if symptoms occur, reduction of dosage is suggested. Bradycardia, nasal stuffiness, mild dryness of mouth, and gastrointestinal symptoms including distention, constipation, flatus, and diarrhea occur occasionally; these generally can be relieved by reducing dosage. Nausea and vomiting have been reported in only a few patients. Sore tongue or "black tongue," pancreatitis, and inflammation of salivary glands may occur.

Weight gain and edema occur infrequently and are relieved by administering a thiazide diuretic; if edema progresses or signs of pulmonary congestion appear, discontinue drug. A rise in BUN has been observed. Other rare reactions include breast enlargement, lactation, impotence, decreased libido, skin rash, mild arthralgia, myalgia, paresthesias, Bell's palsy, parkinsonism, psychic disturbances including nightmares, reversible mild psychoses or depression. Urine exposed to air after voiding may darken because of breakdown of methyldopa or its metabolites.

Note: Dosage should be limited initially to 500 mg daily when following previous antihypertensive agents other than thiazides. Maximal recommended daily dose is 3.0 g. Patients with impaired renal function may respond to smaller doses than patients with normal kidney function. Syncope in older patients has been related to increased sensitivity in those with advanced arteriosclerotic vascular disease; this may be avoided by lower doses. Tolerance occasionally seen either early or late, but more likely between second and third month after initiation of therapy; increased dosage or combined therapy with a thiazide frequently restores effective control.

How Supplied: Tablets, containing 250 mg methyldopa each, in single-unit packages of 100 and bottles of 100 and 1000; Tablets, containing 500 mg methyldopa each, in single-unit packages of 100 and bottles of 100.

For more detailed information, consult your MSD representative or see full prescribing information. Merck Sharp & Dohme, Division of Merck & Co., INC., West Point, Pa. 19486

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Neither inconvenient, unpalatable, expensive potassium supplements nor special K^+ rich diets are needed as a rule. Just 'Dyazide' once or twice daily for control of edema.

Before prescribing, see complete prescribing information in SK&F literature or *PDR*. The following is a brief summary.

Indications: Edema associated with congestive heart failure, cirrhosis of the liver, the nephrotic syndrome; steroid-induced and idiopathic edema; edema resistant to other diuretic therapy. Also, mild to moderate hypertension.

Contraindications: Pre-existing elevated serum potassium. Hypersensitivity to either component. Continued use in progressive renal or hepatic dysfunction or developing hyperkalemia.

Warnings: **Do not use dietary potassium supplements or potassium salts unless hypokalemia develops or dietary potassium intake is markedly impaired.** Enteric-coated potassium salts may cause small bowel stenosis with or without ulceration. Hyperkalemia (>5.4 mEq/L) has been reported in 4% of patients under 60 years, in 12% of patients over 60 years, and in less than 8% of patients overall. Rarely, cases have been associated with cardiac irregularities. Accordingly, **check serum potassium during therapy, particularly in patients with suspected or confirmed renal insufficiency (e.g., elderly or diabetics). If hyperkalemia develops, substitute a thiazide alone. If spironolactone is used concomitantly with 'Dyazide', check serum potassium frequently**—both can cause potassium retention and sometimes hyperkalemia. Two deaths have been reported in patients on such combined therapy (in one, recommended dosage was exceeded; in the other, serum electrolytes were not properly monitored). Observe patients on 'Dyazide' regularly for possible blood dyscrasias, liver damage or other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving Dyrenium (triamterene, SK&F). Rarely, leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with the thiazides. Watch for signs of impending coma in acutely ill cirrhotics. Thiazides are reported to cross the placental barrier and appear in breast milk. This may result in fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly other adverse reactions that have occurred in the adult. When used during pregnancy or in women who might bear children, weigh potential benefits against possible hazards to fetus.

Precautions: Do periodic serum electrolyte and BUN determinations. Do periodic hematologic studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in postsympathectomy patients. The following may occur: hyperuricemia and gout, reversible nitrogen retention, decreasing alkali reserve with possible metabolic acidosis, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), digitalis intoxication (in hypokalemia). Use cautiously in surgical patients. Concomitant use with antihypertensive agents may result in an additive hypotensive effect.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis; rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting (may indicate electrolyte imbalance), diarrhea, constipation, other gastrointestinal disturbances. Rarely, necrotizing vasculitis, paresthesias, icterus, pancreatitis, and xanthopsia have occurred with thiazides alone.

Supplied: Bottles of 100 capsules; in Single Unit Packages of 100 (intended for institutional use only).

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'Dyazide' gets excess water and salt out and helps keep essential potassium in.

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Before prescribing, please consult complete product information, a summary of which follows:

Indications: Acute, recurrent or chronic nonobstructed urinary tract infections (primarily pyelonephritis, pyelitis, and cystitis) due to susceptible organisms. ***Note:* Carefully coordinate *in vitro* sulfonamide sensitivity tests with bacteriologic and clinical response; add aminobenzoic acid to follow-up culture media. The increasing frequency of resistant organisms limits the usefulness of antibacterials, including sulfonamides, especially in chronic or recurrent urinary tract infections.** Measure sulfonamide blood levels as variations may occur; 20 mg/100 ml should be maximum total level.

Contraindications: Sulfonamide hypersensitivity; pregnancy at term and during nursing period; infants less than two months of age.

Warnings: Safety during pregnancy has not been established. Sulfonamides should not be used for group A beta-hemolytic streptococcal infections and will not eradicate or prevent sequelae (rheumatic fever, glomerulonephritis) of such infections. Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been reported and early clinical signs (sore throat, fever, pallor, purpura or jaundice) may indicate serious blood disorders. Frequent CBC and urinalysis with microscopic examination are recommended during sulfonamide therapy. Insufficient data on children under six with chronic renal disease.

Precautions: Use cautiously in patients with impaired renal or hepatic function, severe allergy, bronchial asthma; in glucose-6-phosphate dehydrogenase-deficient individuals in whom dose-related hemolysis may occur. Maintain adequate fluid intake to prevent crystalluria and stone formation.

Adverse Reactions: *Blood dyscrasias* (agranulocytosis, aplastic anemia, thrombocytopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia); *allergic reactions* (erythema multiforme, skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis); *gastrointestinal reactions* (nausea, emesis, abdominal pains, hepatitis, diarrhea, anorexia, pancreatitis and stomatitis); *CNS reactions* (headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo and insomnia); *miscellaneous reactions* (drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L.E. phenomenon). Due to certain chemical similarities with some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia as well as thyroid malignancies in rats following long-term administration. Cross-sensitivity with these agents may exist.

Dosage: Systemic sulfonamides are contraindicated in infants under 2 months of age (except adjunctively with pyrimethamine in congenital toxoplasmosis).

Usual adult dosage: 2 Gm (4 tabs or teasp.) initially, then 1 Gm *b.i.d.* or *t.i.d.* depending on severity of infection.

Usual child's dosage: 0.5 Gm (1 tab or teasp.)/20 lbs of body weight initially, then 0.25 Gm/20 lbs *b.i.d.* Maximum dose should not exceed 75 mg/kg/24 hrs.

Supplied: Tablets, 0.5 Gm sulfamethoxazole; Suspension, 0.5 Gm sulfamethoxazole/teaspoonful.

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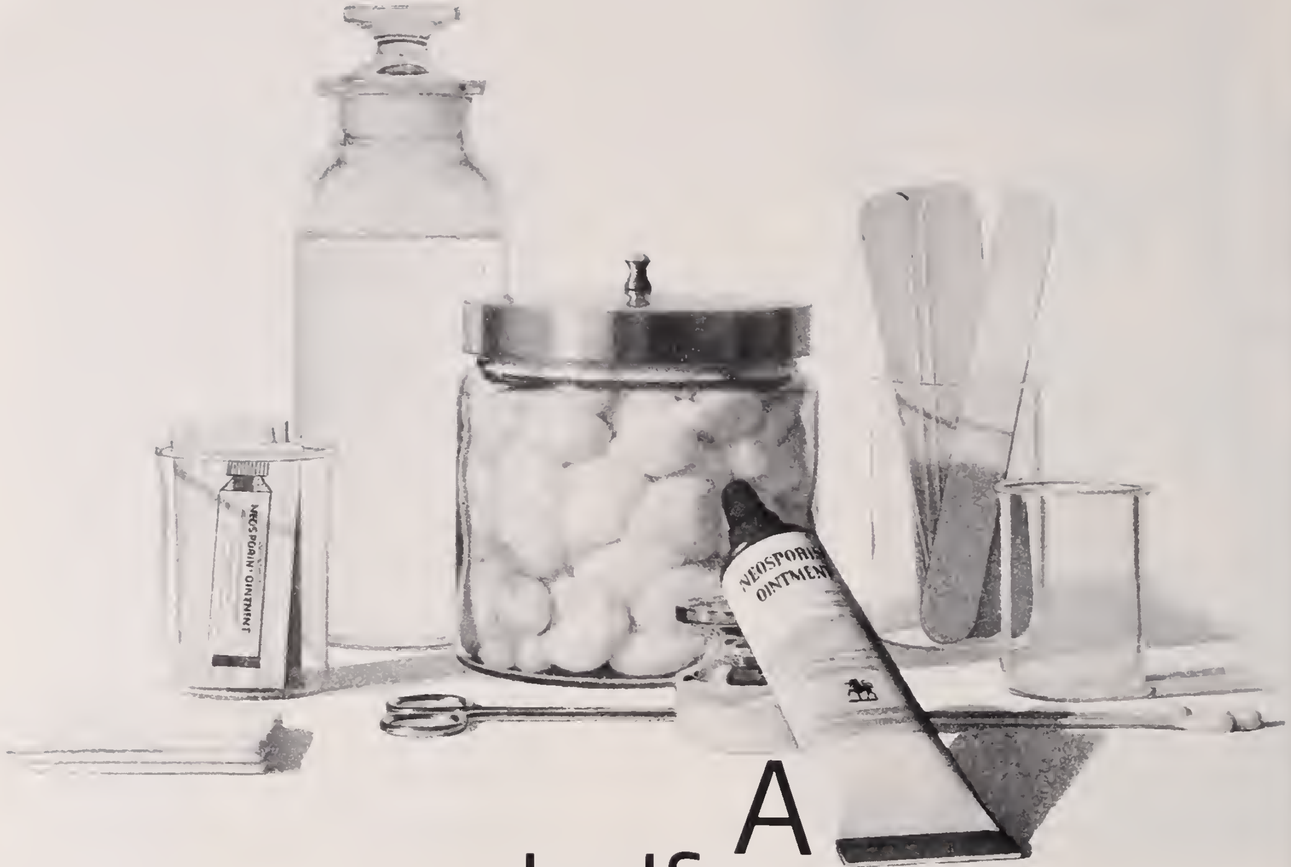

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In either case, it's good medicine. Whether for lacerations,
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Neosporin® Ointment provides broad antibacterial coverage against common
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Each gram contains: Aerosporin® brand Polymyxin B Sulfate 5,000 units; zinc bacitracin 400 units;
neomycin sulfate 5 mg (equivalent to 3.5 mg neomycin base); special white petrolatum qs.
In tubes of 1 oz and 1/2 oz and 1/32 oz (approx.) foil packets.

INDICATIONS: *Therapeutically,* used as an adjunct to appropriate systemic therapy for topical infections, primary or secondary, due to susceptible organisms, as in: • infected burns, skin grafts, surgical incisions, otitis externa • primary pyodermas (impetigo, ecthyma, sycosis vulgaris, paronychia) • secondarily infected dermatoses (eczema, herpes, and seborrheic dermatitis) • traumatic lesions, inflamed or suppurating as a result of bacterial infection.

Prophylactically, the ointment may be used to prevent bacterial contamination in burns, skin grafts, incisions, and other clean lesions. For abrasions, minor cuts and wounds accidentally incurred, its use may prevent the development of infection and permit wound healing.

CONTRAINDICATIONS: Not for use in the eyes or external ear canal if the eardrum is perforated. This product is contraindicated in those individuals who have shown hypersensitivity to any of the components.

WARNING: Because of the potential hazard of nephrotoxicity and ototoxicity due to neomycin, care should be exercised when using this product in treating extensive burns, trophic ulceration and other extensive conditions where absorption of neomycin is possible. In burns where more than 20 percent of t body surface is affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended.

PRECAUTIONS: As with other antibacterial preparations, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropria measures should be taken if this occurs.

ADVERSE REACTIONS: Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of pe allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section).

Complete literature available on request from Professional Services Dept.

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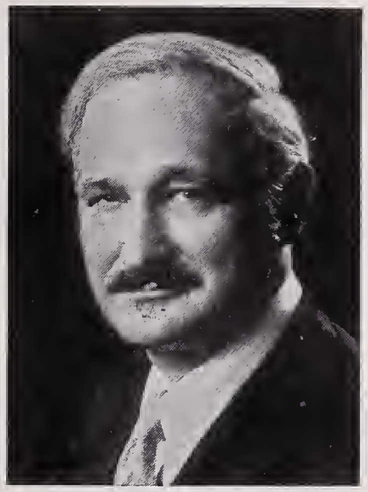
President's Message

On returning to Kansas City, I had some thoughts regarding the recent Annual Session of the Missouri State Medical Association which I felt would be of interest. It is always reassuring to see the democratic process prevail.

The resolution regarding unified membership was discussed at length before the Reference Committee and on the floor of the House of Delegates. The reason for the resolution made good sense, for the proponents believed that this represented a vote of confidence for the American Medical Association, particularly in view of the AMA's recent actions in Washington and in the courts.

The constant and continuing swell of medical- and health-related bills coming before the Congressional committees needs the utmost attention of the physicians in the country, who cannot possibly keep up with this formidable task. The American Medical Association has been "bird-dogging" all bills relating to health care matters and National Health Insurance and effectively testifying at appropriate times. They have been most impressive. The aggressive actions by the Board of Trustees have been soundly applauded by all of us.



R. Allen Chandler, M.D.

The delegates voting against the resolution were not rebelling, but they did not like the "mandatory" inference. It was their feeling that many members of county and state medical societies would resign rather than be compelled to join. The most erudite speakers against the resolution were not rebellious or anti-American Medical Association, but they felt that many physicians, upon seeing the changes that had taken place and the increasing effectiveness of the AMA, would join voluntarily. In this time of crisis, with federal legislation affecting every physician in the country, I believe they were right. Recent figures reflect an increasing membership in every state, including Missouri. I further believe that the financial crisis and the reduction of the staff of our national Association had very little to do with the new membership increase, but that it is attributable to the new fighting stance of the young and more aggressive members added to the Board of Trustees, who are listening to the grassroots.

All in all, the Annual Session was good. The announcement of the Missouri State Malpractice Insurance was a giant step forward and places Missouri far ahead of many other states in the professional liability insurance crisis.

Dr. James Cope, the poet-laureate physician of Missouri, bowed out as your President after a great productive year. He served you well, and I hope to continue to follow and enhance his policies and those of the Council and delegates, which have proven so sound. The Council and I look forward to the challenge of the year ahead.

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Woman's Auxiliary

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Think about it. If we would *really* pool our efforts in chosen and appropriate areas and enjoy the concerted action of both physicians and their wives, we could . . .

. . . double our numbers.
. . . strengthen our informed voice.
. . . cooperate to help improve the well-being of the communities in which we live.

With the starting of this new organizational year, both groups, indeed, are at the moment of decision. Both seek meaningful areas of activity and, additionally, the most efficient and effective avenues for implementing our goals (in terms of finances, time and persons to carry out our programs).

Actually, the members of the Auxiliary may represent that unrealized potential which could allow the physicians to take some needed action. The Auxiliary is 1,750 strong. Won't that help? We may not be able to bolster the finances, but we can provide "people power" and we do have time. Also, of course, Auxiliary members have the greatest plus of all—dedication to and an understanding of the MSMA goals. They, too, are ours.

Mrs. William R. McPhee
President

So, we hope you will include us in your plans!! We think that we can help YOU help people. Ask us! *We'll never know how much good we can do together until we do it!*

County Society News

FIRST DISTRICT

COUNCILOR
JOHN N. MARTIN, ST. JOSEPH

Buchanan County Medical Society

Forty St. Joseph and Northwest Missouri physicians attended the April 9 dinner meeting and program of the Buchanan County Medical Society at the Pony Express Restaurant in St. Joseph.

The annual program on "Cancer" was presented by Dr. Ned D. Rodes, project director of the Breast Cancer Demonstration Project of the Cancer Research Center in Columbia. The speaker was enthusiastic about the lifesaving aspects of the national program on detection of cancer of the breast.

The project is jointly sponsored by the American Cancer Society and the National Cancer Institute.

Dr. Rodes noted that the incidence of cancer was four times the number of cases anticipated by the sponsors of the Detection Program. He observed that early detection and treatment is still the best answer in saving lives that might be taken by cancer.

Dr. William B. O'Connor, President, presided at the business meeting of the Society. The speaker was introduced by Dr. Edward H. Andres, Program Chairman. The meeting had been postponed one week from the scheduled date because of a blizzard which made area roads impassable.

Carl K. Ness, M.D., *Secretary*

TENTH DISTRICT

COUNCILOR
EUGENE T. HANSBROUGH, M.D.,
POPLAR BLUFF

Mineral Area Medical Society

Approximately 50 persons heard Helen Palkes, chief psychologist at St. Louis Children's Hospital, speak on "The Hyperactive Child: Parental and Professional Challenge" at the 18th Annual Auxiliary Banquet sponsored by the Mineral Area Medical Society on March 31 in Farmington.

Dr. Palkes, who is the granddaughter of an early Lead Belt merchant, discussed parental counseling and the use of behavior modification techniques in controlling various disturbances of childhood. She was introduced by Dr. Norma Farmer of Farmington, President of the Society. Other officers at the head table included Vice-President and Mrs. Rober Hoye and Secretary and Mrs. C. W. Chastain.

Members and guests present included Dr. and Mrs. Carlos Borromeo, Dr. and Mrs. Venai Raksakulthai, Dr. and Mrs. Tom Burcham, Dr. and Mrs Stanton Hardy, Dr. and Mrs. Marvin Grossman Dr. and Mrs. David Wilson, Dr. and Mrs. Cimchies. Dr. and Mrs. Edward Mardini, Dr. and Mrs. Jay Tuttle, Dr. and Mrs. Pairat, Dr. and Mrs. N. K Datta, Dr. and Mrs. Paul Dennis, Dr. and Mrs A. R. Rao, Dr. and Mrs. Juan Cancelada, Dr. and Mrs. H. D. Dierker, Dr. and Mrs. G. A. Oliver, Dr. and Mrs. R. A. Huckstep, Dr and Mrs. Jack Mullen. Dr. and Mrs. A. G. Karraker, Dr. and Mrs. J. A. Pichardo, Dr. George B. Neukom and Dr. Theodore Bousquet.

C. W. Chastain, M.D., *Secretary*

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New Members

Stephen W. Churchill, M.D., 6301 Rockhill, Kansas City, has become a member of Jackson County Medical Society. Dr. Churchill is a native of McPherson, Kan., received his preliminary education at the University of Kansas and his M.D. degree at the University of Kansas in 1966. He specializes in child psychiatry.

Jack R. Collins, M.D., 216 S. Kingshighway, St. Louis, has become a member of St. Louis County Medical Society. Dr. Collins is a native of Hannibal, received his preliminary education at Iowa State University and his M.D. degree at the University of Missouri in 1965. He specializes in anesthesiology.

Kapal Dev Datta, M.D., 5400 Arsenal, St. Louis, has become a member of St. Louis Medical Society. Dr. Datta is a native of India, received his preliminary education at Jullundar City (Panjab) and his M.D. degree at Amritsar Medical College in 1952. He specializes in psychiatry.

Wayne J. Daum, M.D., 50 Hill Dr., St. Louis, has become a member of St. Louis Medical Society. Dr. Daum is a native of Ohio, received his preliminary education at John Carroll University and his M.D. degree at St. Louis University in 1971. He will begin his residency in orthopedics in July.

Mark L. Davidner, M.D., 8300 Troost, Kansas City, has become a member of Jackson County Medical Society. Dr. Davidner is a native of Saskatchewan, received his preliminary education at the University of Saskatchewan and his M.D. degree at the University of Saskatchewan in 1968. He specializes in hematology.

Dominic S. Francisco, M.D., 777 S. New Ballas Rd., St. Louis, has become a member of St. Louis Medical Society. Dr. Francisco is a native of Ohio, received his preliminary education at Ohio State University and his M.D. degree at St. Louis University in 1964. He specializes in radiology.

Richard W. Kalbac, M.D., 4320 Wornall Rd., Kansas City, has become a member of Jackson County Medical Society. Dr. Kalbac is a native of St. Louis, received his preliminary education at Washington University and his M.D. degree at the University of Missouri in 1970. He specializes in obstetrics and gynecology.

Harold H. Kerr, M.D., 12th & Grand, Kansas City, has become a member of Jackson County Medical Society. Dr. Kerr is a native of Akron, Ia., received his preliminary education at the University of Nebraska and his M.D. degree at the University of Nebraska in 1941. He specializes in thoracic surgery.

Frederick T. Kraus, M.D., 615 S. New Ballas Rd., St. Louis, has become a member of St. Louis Medical Society. Dr. Kraus is a native of Oklahoma, received his preliminary education at the College of William & Mary and his M.D. degree at Washington University in 1955. He specializes in pathology.

Larry E. Lee, M.D., 2929 Baltimore, Kansas City, has become a member of Jackson County Medical Society. Dr. Lee is a native of Mt. Vernon, Ill., received his preliminary education at St. Louis University and his M.D. degree at the University of Illinois in 1967. He specializes in radiology.

George C. McAnelly, M.D., 9406 E. 63rd, Kansas City, has become a member of Jackson County Medical Society. Dr. McAnelly is a native of Stillwater, Okla., received his preliminary education at Oklahoma State University and his M.D. degree at the University of Oklahoma in 1968. He is in family practice.

James E. Mallow, M.D., 44th & Wornall, Kansas City, has become a member of Jackson County Medical Society. Dr. Mallow is a native of Rapid City, S. D., received his preliminary education at the University of South Dakota and his M.D. degree at the University of Colorado in 1967. He specializes in anesthesiology.

Andrew I. Myers, M.D., 1734 E. 63rd, Kansas City, has become a member of Jackson County Medical Society. Dr. Myers is a native of Kansas City, received his preliminary education at Washington University and his M.D. degree at the University of Kansas in 1973. He is in family practice.

W. Kirt Nichols, M.D., 807 Stadium, Columbia, has become a member of Boone County Medical Society. Dr. Nichols is a native of Flint, Mich., received his preliminary education at the University of Michigan and his M.D. degree at the University of Michigan in 1966. He specializes in general surgery.

Bill Nicolay, M.D., Madison Memorial Hospital, Fredericktown, has become a member of Mineral

Area County Medical Society. Dr. Nicolay is a native of St. Louis, received his preliminary education at Washington University and his M.D. degree at Washington University in 1954. He specializes in radiology.

Eng Liat Ong, M.D., 6150 Oakland, St. Louis, has become a member of St. Louis Medical Society. Dr. Ong is a native of the Philippines, received his preliminary education at the University of Santo Tomas and his M.D. degree at the University of Santo Tomas in 1968. He specializes in general surgery.

Carl A. Petit, M.D., 4620 J. C. Nichols Pkwy., Kansas City, has become a member of Jackson County Medical Society. Dr. Petit is a native of Lima, Peru, received his preliminary education at Alfonso Ugarte College and his M.D. degree at Cordoba University (Argentina) in 1960. He specializes in surgery.

Marcus E. Raichle, M.D., 4550 Scott, St. Louis, has become a member of St. Louis Medical Society. Dr. Raichle is a native of Washington, received his preliminary education at the University of Washington and his M.D. degree at the University of Washington in 1964. He specializes in neurology.

Carl M. Regier, M.D., Skaggs Community Hospital, Branson, has become a member of Ozarks County Medical Society. Dr. Regier is a native of Chicago, received his preliminary education at Northwestern University and his M.D. degree at the University of Missouri in 1966. He specializes in radiology.

Chaiyarat Sermchief, M.D., 703 W. Main, Fredericktown, has become a member of Mineral Area County Medical Society. Dr. Sermchief is a native of Thailand, received his preliminary education at the Faculty of Medical Sciences, and his M.D. degree at Chiengmai Medical School in 1967. He specializes in obstetrics and gynecology.

Louis P. Stickley, M.D., 621 S. New Ballas, St. Louis, has become a member of St. Louis Medical Society. Dr. Stickley is a native of Ohio, received his preliminary education at St. Louis University and his M.D. degree at St. Louis University in 1966. He specializes in cardology.

C. F. Stubblefield, M.D., Veterans Administration Hospital, Poplar Bluff, has become a member of Butler-Wayne-Ripley-Carter County Medical Society. Dr. Stubblefield is a native of Yazoo City, Miss., received his preliminary education at Millsaps Col-

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ege and his M.D. degree at the University of Virginia in 1948. He specializes in internal medicine.

Emel A. Sumer, M.D., 103 N. Taylor, St. Louis, has become a member of St. Louis County Medical Society. Dr. Sumer is a native of Turkey, received his preliminary education at Istanbul University and his M.D. degree at Istanbul Medical Faculty n 1957. He specializes in child psychiatry.

Jose R. Thomas-Richards, D.O., 44 & Wornall, Kansas City, has become a member of Jackson County Medical Society. Dr. Thomas-Richards is a native of Venezuela, received his preliminary education at Andrews University and his M.D. degree at Kansas City College of Osteopathic Medicine in 1970. He specializes in orthopedic surgery.

Gianfranco Turati, M.D., 1091 Mariners Point, St. Louis, has become a member of St. Louis Couny Medical Society. Dr. Turati is a native of Rovigo, taly, received his preliminary education at Liceo Classico and his M.D. degree at the Medical School of Padua in 1960. He specializes in obstetrics and gynecology.

Gino Tutera, M.D., 11055 Cedar, Shawnee Mission, Kan., has become a member of Jackson Couny Medical Society. Dr. Tutera is a native of Rome, taly, received his preliminary education at the University of Missouri and his M.D. degree at the University of Missouri in 1971. He specializes in obstetrics and gynecology.

Martin L. Willman, M.D., 1325 S. Grand, St. Louis, has become a member of St. Louis Medical Society. Dr. Willman is a native of Kentucky, received his preliminary education at the University of Kentucky and his M.D. degree at the University of Kentucky in 1972. He specializes in otorhinoaryngology.

K. G. Wilhelm, M.D., VA Hospital, Columbia, has become a member of Boone County Medical Society. Dr. Wilhelm is a native of Oak Park, Ill., received his preliminary education at Providence College and his M.D. degree at the University of Michigan in 1967. He specializes in general surgery.

Joseph G. Holman, M.D., 4620 J. C. Nichols Pkwy., Kansas City, has become a member of Jackson County Medical Society. Dr. Holman is a native of Winfield, Kan., received his preliminary educaion at Kansas State University and his M.D. degree at the University of Kansas in 1965. He specializes n allergy.

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The cerebral or peripheral vascular disease patient often has coexisting disease[1] which calls for another drug along with his vasodilator. It may be a hypoglycemic, miotic, antihypertensive, diuretic, anticoagulant, corticosteroid, or coronary vasodilator.

Vasodilan is not incompatible with any of these drugs—no treatment conflict has been reported. And, unlike other vasodilators, Vasodilan has not been reported to affect carbohydrate metabolism, liver function, or intraocular pressure—or to complicate treatment of diabetes, hypertension, peptic ulcer, glaucoma, or liver disease.

In fact, there are no known contraindications to the use of Vasodilan in recommended oral doses, other than that it should not be given in the presence of frank arterial bleeding or immediately postpartum.

Indications: Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows:

Possibly Effective:

1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.
3. Threatened abortion.

Final classification of the less-than-effective indications requires further investigation.

Composition: Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg.

Dosage and Administration: 10 to 20 mg. three or four times daily.

Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

Adverse Reactions: On rare occasions, oral administration of the drug has been associated in time with the occurrence of severe rash. When rash appears, the drug should be discontinued. Occasional overdosage effects such as transient palpitation or dizziness are usually controlled by reducing the dose.

Supplied: Tablets, 10 mg.—bottles of 100, 1000, 5000 and Unit Dose; 20 mg.—bottles of 100, 500 and Unit Dose.

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Mead Johnson LABORATORIES

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[1] Gertler, M. M., et al.: Geriatrics *25*:134-148 (May) 1970.

When serum cholesterol demands attention...

atients may need…
- Diet control
- A proven cholesterol-lowering adjunct to diet*
- Convenient once-a-day dosage*
- Reasonable cost*

*Choloxin®
(sodium dextrothyroxine)

agent for low density lipoproteins, "type II hyperlipidemia," in euthyroid, non-cardiac patients.

FLINT LABORATORIES
DIVISION OF TRAVENOL LABORATORIES, INC.
Deerfield, Illinois 60015

See reverse side for full prescribing information

Choloxin® (sodium dextrothyroxine)

The Lipid-Lowering Agent with Once-A-Day Dosage

Four strengths . . . 1, 2, 4, and 6 mg. . . . are available making the scored tablet regimen a flexible dosage system. And, for most patients, CHOLOXIN tablets offer once-a-day dosage.

AN IMPORTANT NOTE:
It has not been established whether the drug-induced lowering of serum cholesterol or lipid levels has a detrimental, beneficial, or no effect on the morbidity or mortality due to atherosclerosis or coronary heart disease. Several years will be required before current investigations will yield an answer to this question.

CHOLOXIN® (sodium dextrothyroxine) Single-Tablet-A-Day Dosage Schedules

See prescribing information in package insert reproduced below.

	Starting Dosage	Increased Monthly by	Usual Maintenance	Maximal Recommended
Adult Hypercholesterolemic	1.0-2.0 mg.	1.0-2.0 mg.	4.0-8.0 mg.	4.0-8.0 mg.
Pediatric Hypercholesterolemic	0.05 mg./kg. body weight	0.05 mg./kg.	0.1 mg./kg. body weight	4.0 mg.
Hypothyroid Cardiac	0.5-1.0 mg.	1.0 mg.	4.0 mg.	4.0 mg.

Choloxin®

(sodium dextrothyroxine)

Description

CHOLOXIN (sodium dextrothyroxine) is the sodium salt of the dextrorotatory isomer of thyroxine. It is chemically described as 0-3,5,3′,5′-tetraiodothyronine sodium salt.

Actions

The predominant effect of CHOLOXIN (sodium dextrothyroxine) is the reduction of serum cholesterol levels in hyperlipidemic patients. Beta lipoprotein and triglyceride fractions may also be reduced from previously elevated levels.

Most of the available evidence indicates that CHOLOXIN stimulates the liver to increase catabolism and excretion of cholesterol and its degradation products via the biliary route into the feces. Cholesterol synthesis is not inhibited and abnormal metabolic endproducts do not accumulate in the blood.

Indications

This is not an innocuous drug. Strict attention should be paid to the indications and contraindications.

CHOLOXIN (sodium dextrothyroxine) is an antilipidemic agent used as an adjunct to diet and other measures for the reduction of elevated serum cholesterol (low density lipoproteins) in euthyroid patients with no known evidence of organic heart disease.

The drug is also indicated in the treatment of hypothyroidism in patients with cardiac disease who cannot tolerate other types of thyroid medication.

Before prescribing, note the following: Results from a randomized clinical study have indicated a possible adverse effect when CHOLOXIN is administered to a patient receiving a digitalis preparation. There may be an additive effect. This additive effect may possibly stimulate the myocardium excessively in patients with significant myocardial impairment. CHOLOXIN dosage should not exceed 4 mg per day when the patient is receiving a digitalis preparation concomitantly. Careful monitoring of the total effect of both drugs is important.

It has not been established whether the drug-induced lowering of serum cholesterol or lipid levels has a detrimental, beneficial, or no effect on the morbidity or mortality due to atherosclerosis or coronary heart disease. Several years will be required before current investigations will yield an answer to this question.

Contraindications

The administration of CHOLOXIN (sodium dextrothyroxine) to euthyroid patients with one or more of the following conditions is contraindicated:

1. Known organic heart disease, including angina pectoris; history of myocardial infarction; cardiac arrhythmia or tachycardia, either active or in patients with demonstrated propensity for arrhythmias; rheumatic heart disease; history of congestive heart failure; and decompensated or borderline compensated cardiac status.
2. Hypertensive states (other than mild, labile systolic hypertension).
3. Advanced liver or kidney disease.
4. Pregnancy.
5. Nursing mothers.
6. History of iodism.

Warnings

CHOLOXIN (sodium dextrothyroxine) may potentiate the effects of anticoagulants on prothrombin time. Reductions of anticoagulant dosage by as much as 3D% have been required in some patients. Consequently, the dosage of anticoagulants should be reduced by one-third upon initiation of CHOLOXIN therapy and the dosage subsequently readjusted on the basis of prothrombin time. The prothrombin time of patients receiving anticoagulant therapy concomitantly with CHDLOXIN therapy should be observed as frequently as necessary, but at least weekly, during the first few weeks of treatment.

In the surgical patient, it is wise to consider withdrawal of the drug two weeks prior to surgery if the use of anticoagulants during surgery is contemplated.

When CHOLOXIN is used as thyroid replacement therapy in hypothyroid patients with concomitant coronary artery disease (especially those with a history of angina pectoris or myocardial infarction) or other cardiac disease, treatment should be initiated with care. Special consideration of the dosage schedule of CHOLOXIN is required. This drug may increase the oxygen requirements of the myocardium, especially at high dosage levels. Treated subjects with coronary artery disease must be seen at frequent intervals. If aggravation of angina or increased myocardial ischemia, cardiac failure, or clinically significant arrhythmia develops during the treatment of hypothyroid patients, the dosage should be reduced or the drug discontinued.

Special consideration must be given to the dosage of other thyroid medications used concomitantly with CHOLOXIN. As with all thyroactive drugs, hypothyroid patients are more sensitive to a given dose of CHOLOXIN than euthyroid patients.

Epinephrine injection in patients with coronary artery disease may precipitate an episode of coronary insufficiency. This condition may be enhanced in patients receiving thyroid analogues. These phenomena should be kept in mind when catecholamine injections are required in sodium dextrothyroxine-treated patients with coronary artery disease.

Since the possibility of precipitating cardiac arrhythmias during surgery may be greater in patients treated with thyroid hormones, it may be wise to discontinue CHOLOXIN in euthyroid patients at least two weeks prior to an elective operation. During emergency surgery in euthyroid patients, and in surgery in hypothyroid patients in whom it may be advisable to withdraw therapy, the patients should be carefully observed.

There are reports that sodium dextrothyroxine in diabetic patients is capable of increasing blood sugar levels with a resultant increase in requirements of insulin or oral hypoglycemic agents. Special attention should be paid to parameters necessary for good control of the diabetic state in dextrothyroxine-treated subjects and to dosage requirements of insulin or other antidiabetic drugs. If sodium dextrothyroxine is later withdrawn from patients who had required an increase of insulin (or oral hypoglycemic agents) dosage during its administration, the dosage of antidiabetic drugs should be reduced and adjusted to maintain good control of the diabetic state.

When either or both impaired liver or kidney function are present, the advantages of CHOLOXIN therapy must be weighed against the possibility of deleterious results.

Usage in Women of Childbearing Age

Women of childbearing age with familial hypercholesterolemia or hyperlipemia should not be deprived of the use of this drug; it can be given to those patients exercising strict birth control procedures. Since pregnancy may occur despite the use of birth control procedures, administration of CHOLOXIN (sodium dextrothyroxine) to women of this age group should be undertaken only after weighing the possible risk to the fetus against the possible benefits to the mother. Teratogenic studies in two animal species have resulted in no abnormalities in the offspring.

Precautions

It is expected that patients on dextrothyroxine therapy will show greatly increased serum protein-bound-iodine levels. These increased serum PBI values are evidence of absorption and transport of the drug, and should NOT be interpreted as evidence of hypermetabolism; similarly, they may not be used for titrating the effective dose of CHOLOXIN (sodium dextrothyroxine). PBI values in the range of 10 to 25 mcg% in treated patients are common.

If signs or symptoms of iodism develop during CHOLOXIN therapy, the drug should be discontinued.

A few children with familial hypercholesterolemia have been treated with CHOLOXIN for periods of one year or longer with no adverse effects on growth. However, it is recommended that the drug be continued in patients in this age group only if a significant serum cholesterol-lowering effect is observed.

Adverse Reactions

The side effects attributed to dextrothyroxine therapy are, for the most part, due to increased metabolism, and may be minimized by following the recommended dosage schedule. Adverse effects are least commonly seen in euthyroid patients with no signs or symptoms of organic heart disease; the incidence of adverse effects is increased in hypothyroid patients, and is highest in those patients with organic heart disease superimposed on the hypothyroid state.

In the absence of known organic heart disease, some cardiac changes may be precipitated during sodium dextrothyroxine therapy. In addition to angina pectoris, arrhythmia consisting of extrasystoles, ectopic beats, or supraventricular tachycardia, ECG evidence of ischemic myocardial changes and increase in heart size have been observed. Myocardial infarctions, both fatal and non-fatal, have occurred, but these are not unexpected in untreated patients in the age groups studied. It is not known whether any of these infarcts were drug related.

Changes in clinical status that may be related to the metabolic action of the drug include the development of insomnia, nervousness, palpitations, tremors, loss of weight, lid lag, sweating, flushing, hyperthermia, hair loss, diuresis, and menstrual irregularities. Gastrointestinal complaints during therapy have included dyspepsia, nausea and vomiting, constipation, diarrhea, and decrease in appetite.

Other side effects reported to be associated with CHOLOXIN (sodium dextrothyroxine) therapy include the development of headache, changes in libido (increase or decrease), hoarseness, tinnitus, dizziness, peripheral edema, malaise, tiredness, visual disturbances, psychic changes, paresthesia, muscle pain, and various bizarre subjective complaints. Skin rashes, including a few which appeared to be due to iodism, and itching have been attributed to dextrothyroxine by some investigators. Gallstones have been discovered in occasional dextrothyroxine-treated patients and cholestatic jaundice has occurred in one patient, although its relationship to CHOLOXIN therapy was not established.

In several instances, the previously existing conditions of the patient appeared to continue or progress during the administration of CHOLOXIN; a worsening of peripheral vascular disease, sensorium, exophthalmos, and retinopathy have been reported.

CHOLOXIN potentiates the effects of anticoagulants, such as warfarin or Oicumarol, on prothrombin time, thus indicating a decrease in the dosage requirements of the anticoagulants. On the other hand, dosage requirements of antidiabetic drugs have been reported to be increased during dextrothyroxine therapy (see WARNINGS section).

Dosage and Administration

For **adult** euthyroid hypercholesterolemic patients, the recommended maintenance dose of CHOLOXIN (sodium dextrothyroxine) is 4 to 8 mg per day. The initial daily dose should be 1 to 2 mg to be increased in 1 to 2 mg increments at intervals of not less than one month to a maximum level of 4 to 8 mg daily, if that dosage level is indicated to effect the desired lowering of serum cholesterol.

When used as partial or complete substitution therapy for levothyroxine in hypothyroid patients with cardiac disease who cannot tolerate other types of thyroid medication, the initial daily dose should be 1 mg to be increased in 1 mg increments at intervals of not less than one month to a maximum level of 4 to 8 mg daily, preferably the lower dosage. The maximum in patients receiving digitalis therapy is 4 mg.

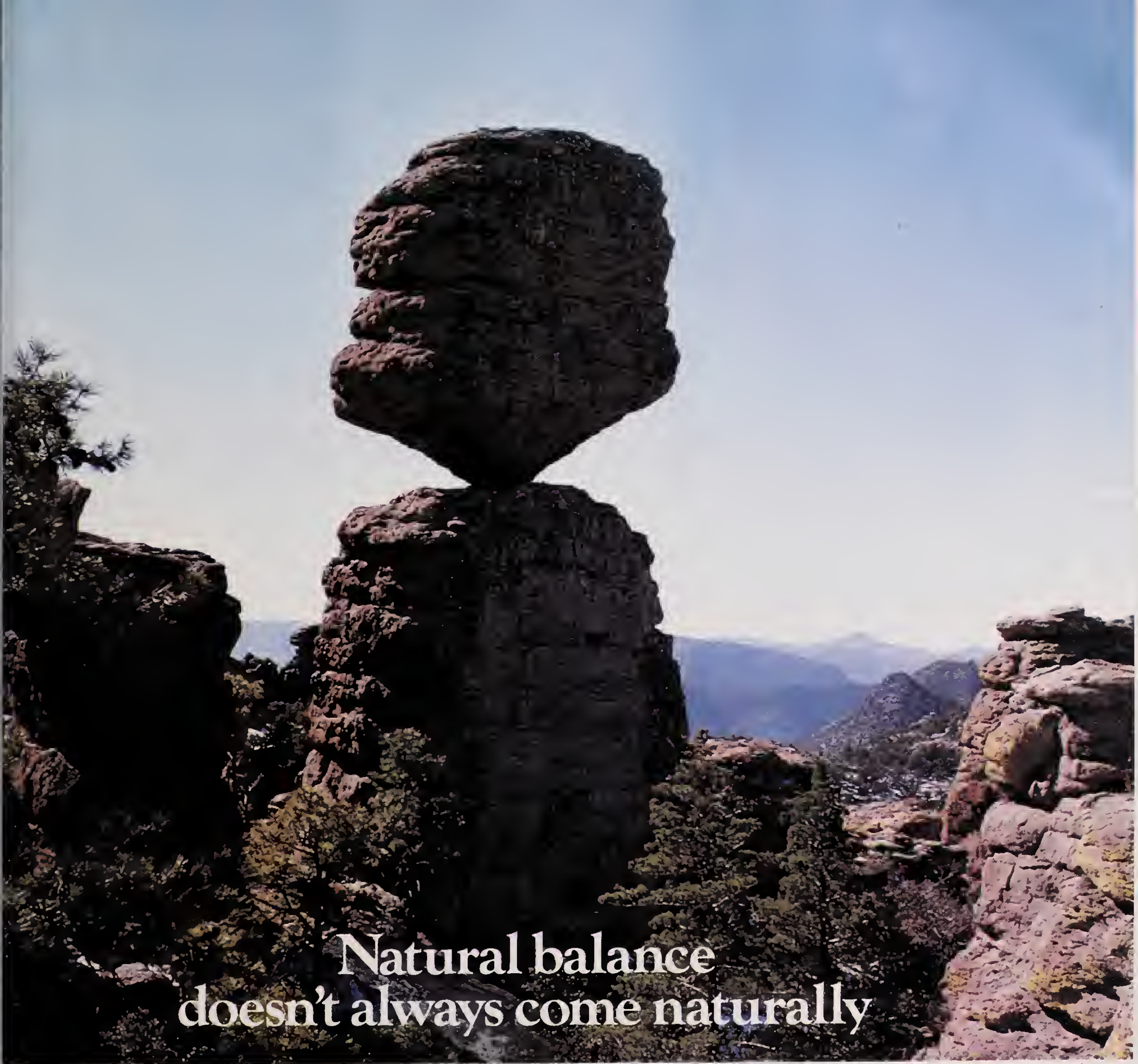
For **pediatric** hypercholesterolemic patients, the recommended maintenance dose of CHOLOXIN is approximately 0.1 mg per kilogram. The initial daily dosage should be approximately 0.05 mg per kilogram to be increased in up to 0.05 mg per kilogram increments at monthly intervals. The recommended maximal dose is 4 mg daily, if that dosage is indicated to effect the desired lowering of serum cholesterol.

If new signs or symptoms of cardiac disease develop during the treatment period, the drug should be withdrawn.

How Supplied

CHOLOXIN (sodium dextrothyroxine) is supplied in prescription packages of scored 1, 2, 4, and 6 mg tablets.

FLINT LABORATORIES
DIVISION OF TRAVENOL LABORATORIES INC
Deerfield, Illinois 60015



Big Balanced Rock, Chiricahua Mountains, Arizona (approx. 1,000 tons)

ound useful in the management of vertigo* associated with eases affecting the vestibular system.

an relieve nausea and vomiting often associated with vertigo.*

sual adult dosage for Antivert/25 for vertigo:* one tablet t.i.d.

lso available as Antivert (meclizine HCl) 12.5 mg. scored lets, for dosage convenience and flexibility.

ntivert/25 (meclizine HCl) 25 mg. *Chewable* Tablets for usea, vomiting and dizziness associated with motion sickness.

EF SUMMARY OF PRESCRIBING INFORMATION

INDICATIONS. Based on a review of this drug by the National Academy of ciences—National Research Council and/or other information, FDA has classified e indications as follows:

Effective: Management of nausea and vomiting and dizziness associated with otion sickness.

Possibly Effective: Management of vertigo associated with diseases affecting the estibular system.

Final classification of the less than effective indications requires further vestigation.

CONTRAINDICATIONS. Administration of Antivert (meclizine HCl) during pregnancy or to women who may become pregnant is contraindicated in view of the teratogenic effect of the drug in rats.

The administration of meclizine to pregnant rats during the 12-15 day of gestation has produced cleft palate in the offspring. Limited studies using doses of over 100 mg./kg./day in rabbits and 10 mg./kg./day in pigs and monkeys did not show cleft palate. Congeners of meclizine have caused cleft palate in species other than the rat.

Meclizine HCl is contraindicated in individuals who have shown a previous hypersensitivity to it.

WARNINGS. Since drowsiness may, on occasion, occur with use of this drug, patients should be warned of this possibility and cautioned against driving a car or operating dangerous machinery.

Usage in Children: Clinical studies establishing safety and effectiveness in children have not been done; therefore, usage is not recommended in the pediatric age group.

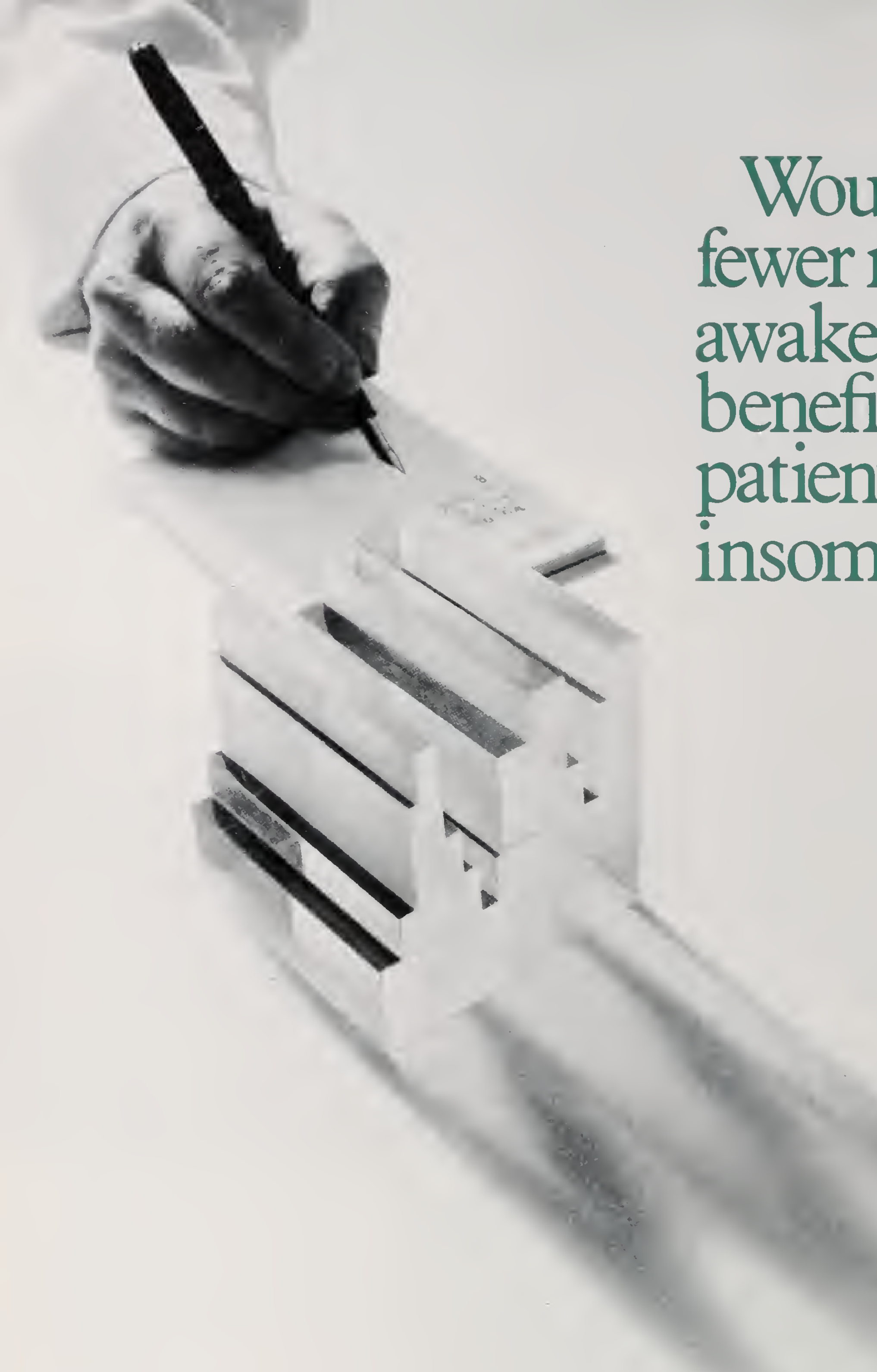
Usage in Pregnancy: See "Contraindications."

ADVERSE REACTIONS. Drowsiness, dry mouth and, on rare occasions, blurred vision have been reported.

More detailed professional information available on request.

ROERIG Pfizer
A division of Pfizer Pharmaceuticals
New York, New York 10017

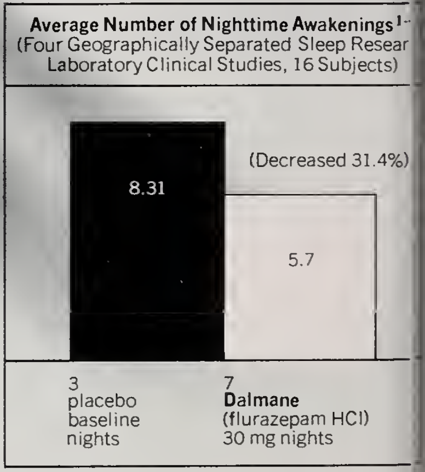
Antivert®/25
(meclizine HCl) 25 mg. Tablets
for vertigo*



Would sleep wit fewer nighttime awakenings benefit your patients with insomnia?

Highly predictable results for your patients with trouble staying asleep...

...can be obtained with Dalma (flurazepam HCl). As shown below, Dalmane significantly reduces nighttime awakenings:[1-4]



And for those with trouble lling asleep or sleeping ng enough…

…Dalmane (flurazepam HCl) so delivers excellent results. inically proven in sleep research boratory studies: on average, eep within 17 minutes that lasts to 8 hours.[5]

Dalmane (flurazepam HCl) relatively safe, seldom auses morning "hang-over".

…and is well tolerated. The sual adult dosage is 30 mg *h.s.*, ut with elderly and debilitated atients, limit the initial dose to 5 mg to preclude oversedation, izziness or ataxia. Evaluation of ossible risks is advised before rescribing.

EFERENCES:

Karacan I, Williams RL, Smith JR: The eep laboratory in the investigation of sleep id sleep disturbances. Scientific exhibit at e 124th annual meeting of the American sychiatric Association, Washington DC, ay 3-7, 1971

Frost JD Jr: A system for automatically ıalyzing sleep. Scientific exhibit at the 4th annual Clinical Convention of the merican Medical Association, Boston, ov 29-Dec 2, 1970; and at the 42nd annual ientific meeting of the Aerospace Medical ssociation, Houston, Apr 26-29, 1971

Vogel GW: Data on file, Medical Department, Hoffmann-La Roche Inc., Nutley NJ

Dement WC: Data on file, Medical Department, Hoffmann-La Roche Inc., Nutley NJ

Data on file, Medical Department, offmann-La Roche Inc., Nutley NJ

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efore prescribing Dalmane (flurazepam Cl), please consult complete product ıformation, a summary of which follows:

ndications: Effective in all types of insomnia haracterized by difficulty in falling asleep, equent nocturnal awakenings and/or early norning awakening; in patients with recurring nsomnia or poor sleeping habits; and in cute or chronic medical situations requiring estful sleep. Since insomnia is often transient nd intermittent, prolonged administration is enerally not necessary or recommended.

ontraindications: Known hypersensitivity flurazepam HCl.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. Caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Use in women who are or may become pregnant only when potential benefits have been weighed against possible hazards. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated, initial dosage should be limited to 15 mg to preclude oversedation, dizziness and/or ataxia. If combined with other drugs having hypnotic or CNS-depressant effects, consider potential additive effects. Employ usual precautions in patients who are severely depressed, or with latent depression or suicidal tendencies. Periodic blood counts and liver and kidney function tests are advised during repeated therapy. Observe usual precautions in presence of impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported were headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins and alkaline phosphatase. Paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity, have also been reported in rare instances.

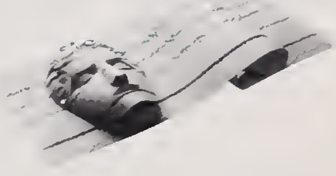
Dosage: Individualize for maximum beneficial effect. *Adults:* 30 mg usual dosage; 15 mg may suffice in some patients. *Elderly or debilitated patients:* 15 mg initially until response is determined.

Supplied: Capsules containing 15 mg or 30 mg flurazepam HCl.

Depend on highly predictable results with

Dalmane®
(flurazepam HCl)

One 30-mg capsule *h.s.*— usual adult dosage
(15 mg may suffice in some patients).
One 15-mg capsule *h.s.*— initial dosage for elderly or debilitated patients.



specifically indicated for insomnia

Objectively proved in the sleep research laboratory:

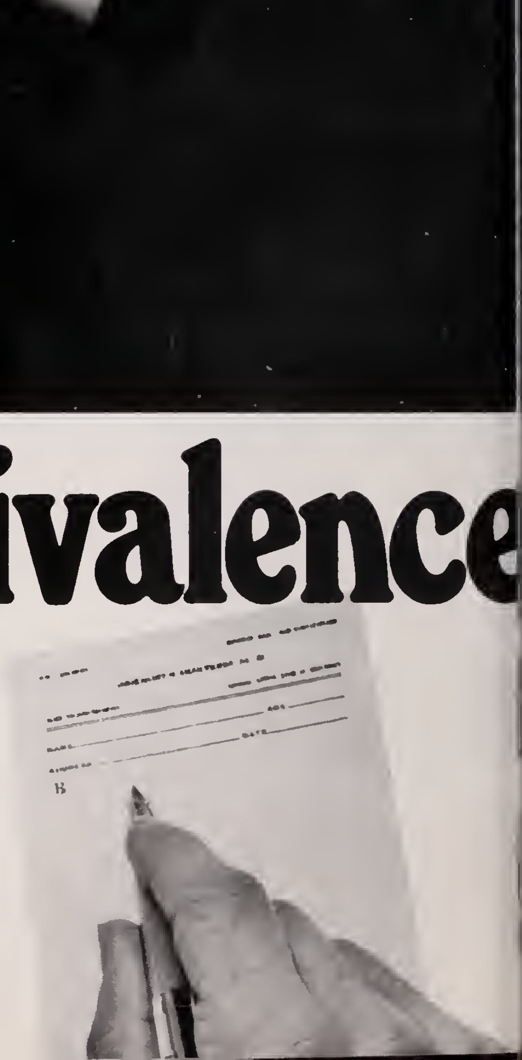
- **sleep with fewer nighttime awakenings**
- **sleep within 17 minutes, on average**
- **sleep for 7 to 8 hours, on average,**

with a single *h.s.* dose.

ROCHE

ROCHE LABORATORIES
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

Bioequivalence



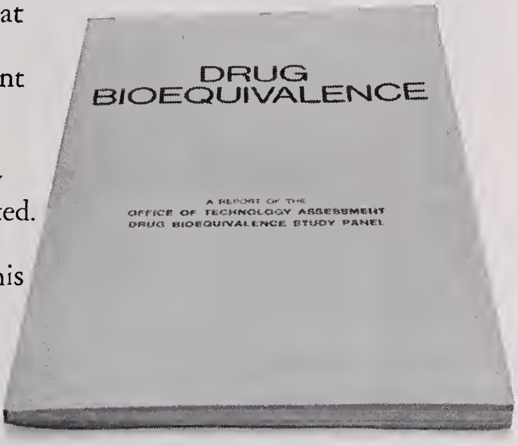
the weight of scientific opinion:

If the pharmacist substituted a hemically equivalent drug for the ne you have specified for your atient—could you be certain of that roduct's safety and effectiveness mply because the chemical content as the same?

Definitely not, unless bioquivalence tests and other quality ssurance checks had been conducted. he pharmaceutical industry and any scientists have maintained this osition for years, but others have uestioned it. Now the Office of echnology Assessment of the ongress of the United States has eported on the issue in its Drug ioequivalence Study.*

Here are a few definitive statents in the O.T.A. report:

"...the problem of bioinequivaency in chemically equivalent prodcts is a real one. Since the studies in hich lack of bioequivalence was emonstrated involved marketed roducts that met current compenial standards, these documented inances constitute unequivocal vidence that neither the present andards for testing the finished roduct nor the specifications for aterials, manufacturing process, nd controls are adequate to ensure that ostensibly equivalent drug products are, in fact, equivalent in bioavailability.



DRUG BIOEQUIVALENCE

A REPORT OF THE
OFFICE OF TECHNOLOGY ASSESSMENT
DRUG BIOEQUIVALENCE STUDY PANEL

"While these therapeutic failures resulting from problems of bioavailability were recognized and well documented, it is entirely possible that other therapeutic failures and/or instances of toxicity that had a similar basis have escaped attention."

The Pharmaceutical Manufacturers Association supports federal legislative amendments that would require manufacturers of duplicate prescription pharmaceutical products, subject to new drug procedures, to document:

(a) chemical equivalence; and
(b) biological equivalence, where bioavailability test methods have been validated as a reliable means of assuring clinical equivalence; or
(c) where such validation is not possible, therapeutic equivalence.

In addition, the PMA supports federal legislation that would require certification of all manufacturers of prescription products before they could start in business, annual inspections and certification thereafter, and strict adherence to FDA regulations on good manufacturing practices.

The overall quality of the United States drug supply is excellent. But only a total quality assurance program, envisaged in these and other policy positions adopted by the PMA Board of Directors in 1974, can bring about acceptable levels of performance by all prescription drug manufacturers and thereby assure the integrity of your prescription...

P·M·A

Pharmaceutical Manufacturers
Association
1155 Fifteenth Street, N.W.
Washington, D.C. 20005

*Copies of the complete report on Drug Bioequivalence may be obtained from the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402.

protecting the integrity of your prescription

In Memoriam

Sidney Rubin, M.D., 701 E. 63rd, Kansas City, a graduate of Wisconsin University, 1946; member of Jackson County Medical Society; age 55; died Dec. 14, 1974.

Frank Hurwitt, M.D., 7801 Holmes, Kansas City, a graduate of National University, 1909; member of Jackson County Medical Society; age 92; died Jan. 31, 1975.

Leo J. Hartnett, M.D., 6744 Clayton, St. Louis, a graduate of St. Louis University, 1931; member of St. Louis Medical Society; age 69; died March 15, 1975.

Helen F. Gibson, M.D., 40 Plaza Square, St. Louis, a graduate of American Medical College, 1901; member of St. Louis Medical Society; age 98; died March 31, 1975.

The advertising in

MISSOURI MEDICINE

keeps you informed and helps pay the publishing costs!

When the local representative calls, tell him you saw his company's ad in your journal.

PRESCRIBING INFORMATION
Antiminth (pyrantel pamoate) Oral Suspension

Actions. Antiminth (pyrantel pamoate) has demonstrated anthelmintic activity against *Enterobius vermicularis* (pinworm) and *Ascaris lumbricoides* (roundworm). The anthelmintic action is probably due to the neuromuscular blocking property of the drug.

Antiminth is partially absorbed after an oral dose. Plasma levels of unchanged drug are low. Peak levels (0.05-0.13μg/ml.) are reached in 1-3 hours. Quantities greater than 50% of administered drug are excreted in feces as the unchanged form, whereas only 7% or less of the dose is found in urine as the unchanged form of the drug and its metabolites.

Indications. For the treatment of ascariasis (roundworm infection) and enterobiasis (pinworm infection).

Warnings. *Usage in Pregnancy:* Reproduction studies have been performed in animals and there was no evidence of propensity for harm to the fetus. The relevance to the human is not known.

There is no experience in pregnant women who have received this drug.

Precautions. Minor transient elevations of SGOT have occurred in a small percentage of patients. Therefore, this drug should be used with caution in patients with pre-existing liver dysfunction.

Adverse Reactions. The most frequently encountered adverse reactions are related to the gastrointestinal system.

Gastrointestinal and hepatic reactions: anorexia, nausea, vomiting, gastralgia, abdominal cramps, diarrhea and tenesmus, transient elevation of SGOT.

CNS reactions: headache, dizziness, drowsiness, and insomnia. Skin reactions: rashes.

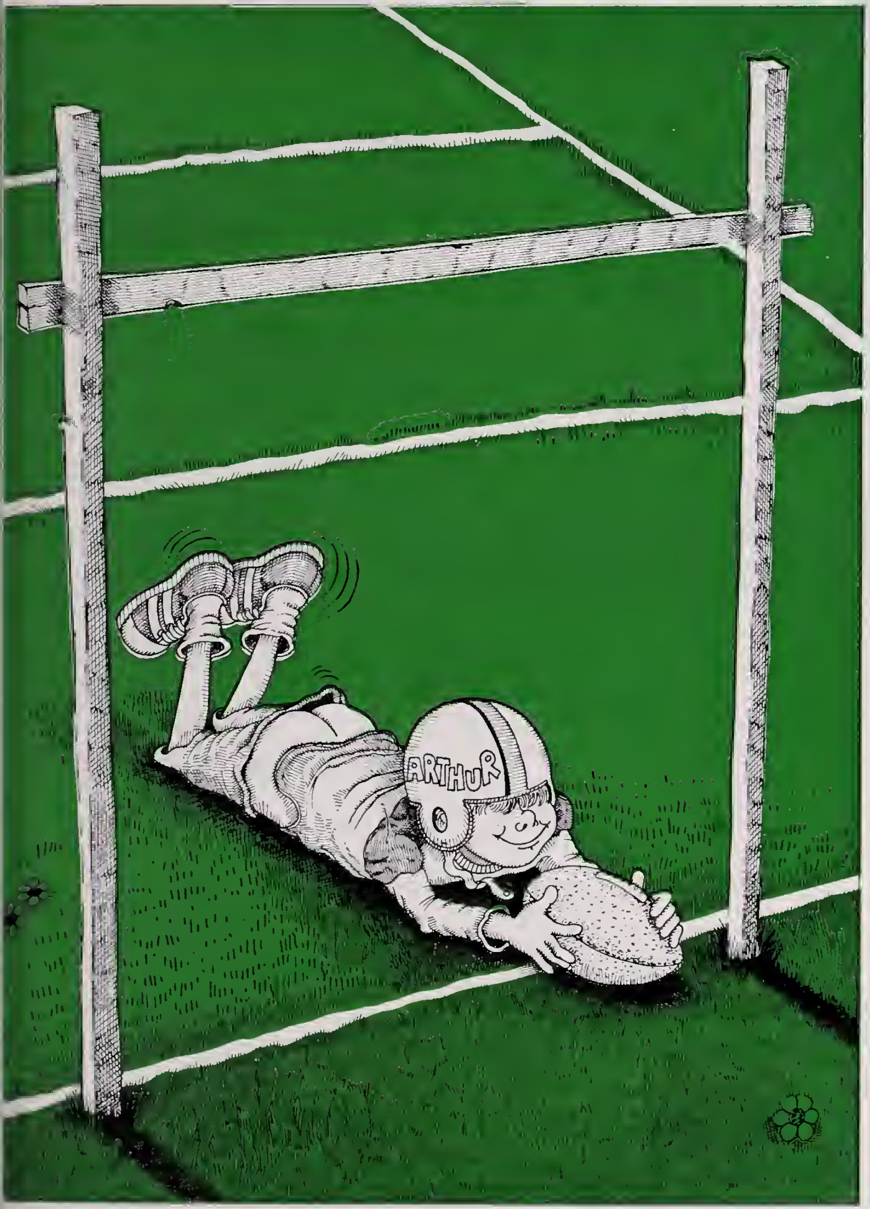
Dosage and Administration. *Children and Adults:* Antiminth Oral Suspension (50 mg. of pyrantel base/ml.) should be administered in a single dose of 11 mg. of pyrantel base per kg. of body weight (or 5 mg./lb.); maximum total dose 1 gram. This corresponds to a simplified dosage regimen of 1 cc. of Antiminth per 10 lb. of body weight. (One teaspoonful = 5 cc.)

Antiminth (pyrantel pamoate) Oral Suspension may be administered without regard to ingestion of food or time of day, and purging is not necessary prior to, during, or after therapy. It may be taken with milk or fruit juices.

How Supplied. Antiminth is available as a pleasant tasting caramel-flavored suspension which contains the equivalent of 50 mg. pyrantel base per ml., supplied in 60 cc. bottles and Unitcups™ of 5 cc. in packages of 12.

ROERIG Pfizer
A division of Pfizer Pharmaceuticals
New York, New York 10017

WORMS BLITZED



A single dose of Antiminth (1 cc. per 10 lbs. of body weight, 1 tsp./50 lbs.—maximum dose, 4 tsp.=20 cc.) offers highly effective control of *both* pinworms and roundworms.

Antiminth has been shown to be extremely well tolerated by children and adults alike in clinical studies.* Pleasantly caramel-flavored, it is non-staining to teeth and oral mucosa on ingestion... doesn't stain stools, linen or clothing.

One prescription can economically treat the entire family.

ROERIG Pfizer
A division of Pfizer Pharmaceuticals
New York, New York 10017

NSN 6505-00-148-6967

Pinworms, roundworms controlled with a single, non-staining dose of

ANTIMINTH®

(pyrantel pamoate)

equivalent to 50 mg. pyrantel/ml.

ORAL SUSPENSION

a on file at Roerig

Please see prescribing information on facing page

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Whether you're a doctor, or a doctor-to-be. No matter what your medical specialty or medical aspirations are, the Air Force has remarkable opportunities for you. You'll practice in modern facilities. With up-to-date equipment. With professionals in every area of Health Care. And the Air Force offers advance study in practically every specialty. All of this plus fringe benefits that are hard to match.

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Previous industrial experience desirable, but not mandatory. Please send resume, with minimum salary requirements, in confidence, to: Box 399, Missouri State Medical Association, 113 Madison, Jefferson City, Mo. 65101.

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LEO H. POLLOCK, M.D.

Missouri Medicine in Review

FORTY YEARS AGO

Through the Jackson County Medical Society, Kansas City has invited the American Medical Association for the 1936 session. The new Municipal Auditorium is now being completed. The original plans were altered to conform to suggestions from the American Medical Association headquarters. Kansas City hotel accommodations are more than ample.

The 78th Annual Session of the Missouri State Medical Association will meet in Excelsior Springs on May 6-9. All general sessions will be held in the Ballroom on the main floor of the Elms Hotel. Under the chairmanship of Dr. Joseph Dauksys of Excelsior Springs, the Clay County Medical Society has been active in its work, and plans for the meeting are progressing in a way which promises an interesting and successful session.

TWENTY-FIVE YEARS AGO

An excellent history of the Missouri State Medical Association appeared in the April, 1950 issue of the *Journal* on pages 249-286. It was written by Robert E. Schlueter, M.D. of St. Louis. The history begins with the organization of the MSMA in 1850 and presents an outline of yearly events which includes photographs of most of the presidents of the Association, beginning with Dr. F. W. G. Thomas of Boonville, who was President in 1851.

The 1875 meeting convened in the Senate Chamber of the State Capitol in Jefferson City on Tuesday, April 20 at 10 A.M. President W. O. Torrey of Hannibal being absent, the meeting was called to order by Second Vice-President, J. S. B. Alleyne of St. Louis.

The Rev. W. G. Keady offered a prayer, G. B. Winston, Chairman of the Committee on Arrangements, extended the greeting and welcome of the profession and citizens of Jefferson City. Twenty-two members answered the roll call.

It is not stated whether or not other members arrived later. There probably were not many because the Corresponding Secretary was instructed to send out notices of the meetings to all physicians of the state 30 days before each meeting.

In the scientific sessions, repair of lacerated perineum and the employment of anesthetics in obstetrics were discussed at length. Laryngeal diphtheria and tracheotomy were discussed throughout most of the two separate sessions. (It must be noted that this was almost ten years before Joseph O'Dwyer invented his apparatus for intubation of the larynx and about 20 years before Behring's diphtheria antitoxin.)

It was decided to hold the next annual meeting in St. Louis.

TEN YEARS AGO

Another scientist well known in his field has been added to the full-time staff of the Menorah Medical Center and the Danciger Institute of Health Sciences in Kansas City. Dr. Jack Katz, assistant professor of otolaryngology at Tulane University School of Medicine, will become director of the Irvin M. Birenboim Audiology Clinic on August 1. His appointment to the post was announced by Dr. Oscar Pinsker, chairman of the Department of Otolaryngology at Menorah Medical Center. A native of New York, Dr. Katz received his Ph.D. in Audiology from the University of Pittsburgh.

Dr. Robert H. Felix, dean of St. Louis University School of Medicine, was honored as the 1964 winner of the Samuel Rubin Award for outstanding achievement in the mental health field. The award was presented by the Postgraduate Center for Mental Health in New York on February 26.

A rural village in Iran will be the work site this spring and summer for a young woman medical student from the University of Missouri School of Medicine. She is Janis L. Burgess, a junior and one of 28 American medical students who has received a Smith Kline & French Laboratories Foreign Fellowship from the Association of American Medical Colleges.

Disruptive anxiety usually meets its match here.

- Often effective when reassurance and counseling are insufficient.
- Three dosage strengths to meet most therapeutic needs.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Relief of anxiety and tension occurring alone or accompanying various disease states.

Contraindications: Patients with known hypersensitivity to the drug.

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Precautions:

ORAL: In the elderly and debilitated and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six.

INJECTABLE: Keep patients under observation, preferably in bed, up to three hours after initial injection; forbid ambulatory patients to operate vehicle following injection; do not administer to patients in shock or comatose states; use reduced dosage (usually 25 to 50 mg) for the elderly or debilitated and for children age twelve or older.

ORAL AND INJECTABLE: Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating compounds such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

With the injectable form, isolated instances of hypotension, tachycardia and blurred vision have been reported; also hypotension associated with spinal anesthesia, and pain following I.M. injection.

Usual Daily Dosage: Individualize for maximum beneficial effects. *Oral: Adults:* Mild and moderate anxiety and tension, 5 or 10 mg *t.i.d.* or *q.i.d.*; severe states, 20 or 25 mg *t.i.d.* or *q.i.d. Geriatric patients:* 5 mg *b.i.d.* to *q.i.d.* (See Precautions.)

For Parenteral Administration: Should be individualized according to diagnosis and response. While 300 mg may be given during a 6-hour period, do not exceed this dose in any 24-hour period. To control acute conditions rapidly, the usual initial adult dose is 50 to 100 mg I.M. or I.V. Subsequent treatment, if necessary, may be given orally. (See Precautions.)

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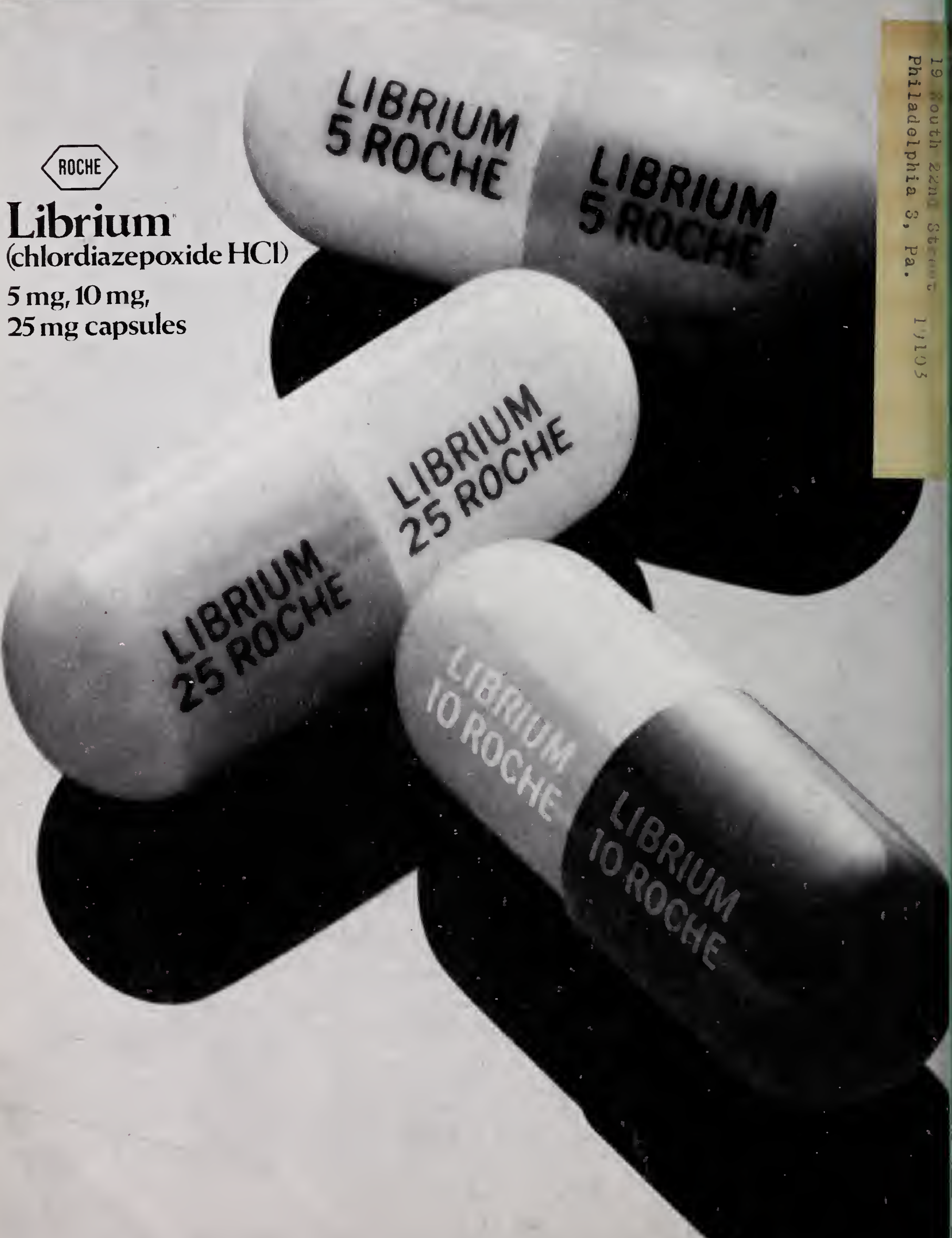
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Missouri Medicine

JOURNAL OF THE MISSOURI STATE MEDICAL ASSOCIATION

JUNE, 1975
VOLUME 72, NUMBER 6

June 20, 1975

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April 1-4, 1976, Kansas City

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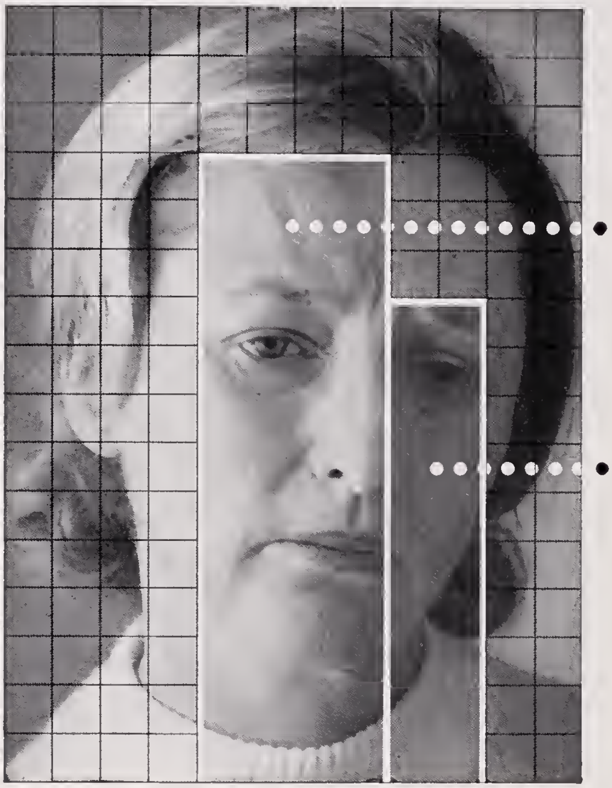

Predominant psychoneurotic anxiety

Associated depressive symptoms

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in fre
and/or severity of grand mal seizur
require increased dosage of standa
convulsant medication; abrupt with
may be associated with temporary
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associated with it are also
relieved.
There are other advan-
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anxiety with secondary
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l. This means that im-
ement is usually apparent
in the patient within a few days rather than in a week or two, although it may take longer in some patients. In addition, Valium (diazepam) is generally well tolerated; as with most CNS-acting agents, caution patients against hazardous occupations requiring complete mental alertness.

Also, because the psychoneurotic patient's symptoms are often intensified at bedtime, Valium can offer an additional benefit. An *h.s.* dose added to the *b.i.d.* or *t.i.d.* treatment regimen can relieve the excessive anxiety and associated depressive symptoms and thus encourage a more restful night's sleep.

Valium®
(diazepam)

2-mg, 5-mg, 10-mg tablets

in psychoneurotic
anxiety states
with associated
depressive symptoms

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habituation and dependence. In
ancy, lactation or women of child-
g age, weigh potential benefit
st possible hazard.
utions: If combined with other psy-
pics or anticonvulsants, consider
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d; drugs such as phenothiazines,
tics, barbiturates, MAO inhibitors
ther antidepressants may potentiate
ion. Usual precautions indicated in
its severely depressed, or with latent
ssion, or with suicidal tendencies.
Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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Missouri Medicine

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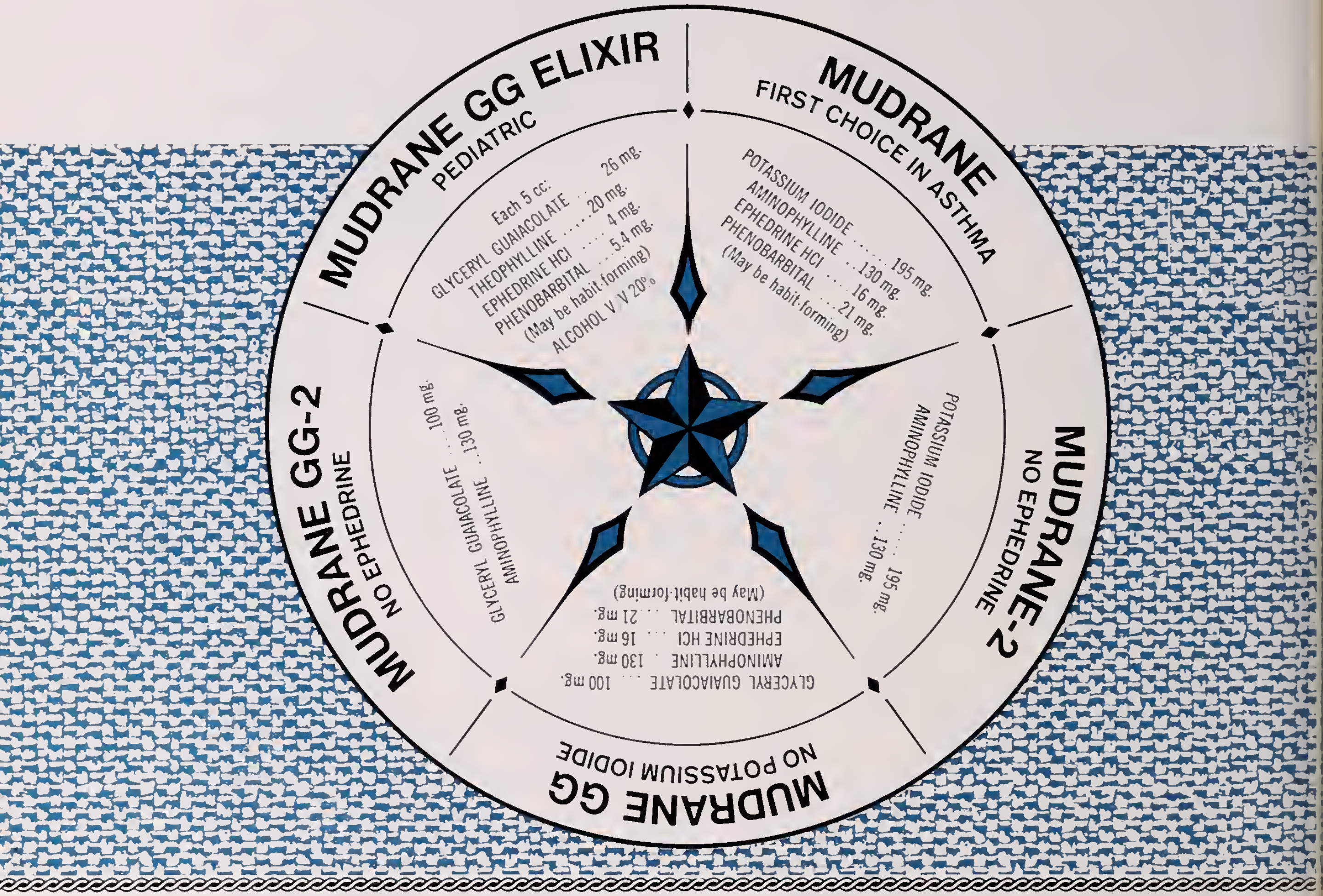
The MUDRANES

Discreet formulations of four well regarded drugs for the relief of bronchial distress—Potassium Iodide, Glyceryl Guaiacolate, Aminophylline, Ephedrine with Phenobarbital (to lessen cardiac stimulation).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AMINOPHYLLINE ..130 mg.
EPHEDRINE HCl ..... 16 mg.
PHENOBARBITAL ... 21 mg.
(May be habit-forming)
MUDRANE-2
NO EPHEDRINE
POTASSIUM IODIDE ..... 195 mg.
AMINOPHYLLINE .. 130 mg.
MUDRANE GG
NO POTASSIUM IODIDE
GLYCERYL GUAIACOLATE .... 100 mg.
AMINOPHYLLINE . 130 mg.
EPHEDRINE HCl .... 16 mg.
PHENOBARBITAL .. 21 mg.
(May be habit-forming)
MUDRANE GG-2
NO EPHEDRINE
GLYCERYL GUAIACOLATE ..... 100 mg.
AMINOPHYLLINE .. 130 mg.
MUDRANE GG ELIXIR
PEDIATRIC
Each 5 cc:
GLYCERYL GUAIACOLATE ... 26 mg.
THEOPHYLLINE ..... 20 mg.
EPHEDRINE HCl ..... 4 mg.
PHENOBARBITAL .... 5.4 mg.
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INDICATIONS: For the prompt symptomatic relief of bronchial asthma, emphysema and bronchiectasis. The Mudranes dilate the bronchi and liquefy mucus plugs. DOSAGE: Tablet; One tablet with a full glass of water 3 or 4 times daily as required. Divide tablet for child's dose. Elixir; Children, 1 cc for each 10 lbs. of body weight. May be repeated 3 or 4 times a day. Adult, one tablespoonful 4 times daily. All doses should be followed with a glass of water.

CONTRAINDICATIONS: Aminophylline/Theophylline is contraindicated in the presence of severe cardiac arrhythmias and patients with massive myocardial damage. Ephedrine, in presence of severe heart disease, extreme hypertension, and in hyperthyroidism. Phenobarbital, in porphyria and in patients with known phenobarbital sensitivity. Potassium Iodide, in pregnancy (to protect the fetus against possible iodine-induced depression of thyroid activity), in tuberculosis (produces gumma dissolution), and in acne; also in the presence of known iodide sensitivity. PRECAUTIONS: Aminophylline/Theophylline should be avoided in patients with massive myocardial damage and/or severe cardiac arrhythmias. In children, overdose may cause vomiting, cardiac arrhythmias, and severe agitation. Ephedrine should be used with caution in the presence of severe cardiac disease, particularly arrhythmias and angina pectoris; avoid in hyperthyroidism and severe hypertension. Phenobarbital may be habit-forming. Avoid overdosage. Potassium Iodide: Discontinue in the presence of skin rash, swelling of the eyelids and severe frontal headache. Long use may cause goiter. ADVERSE REACTIONS: Aminophylline/Theophylline may cause nausea, cardiac arrhythmias, and aggravate severe myocardial disease. It may cause headaches and tachycardia. Vomiting and dizziness are not uncommon. Ephedrine: In patients hypersensitive to CNS stimulation, ephedrine may cause nervousness, tachycardia, extrasystole and ventricular arrhythmias. May cause urinary retention, especially in the presence of partial prostatic obstruction. Psychoneurosis may be aggravated. Pre-existing anginal pain will be aggravated. Phenobarbital may produce severe skin rash. Avoid overdosage. May be habit-forming. Potassium Iodide may cause nausea. Over very long period of use, iodides cause goiter. Discontinue if patient develops skin rash, eye irritation, eyelid swelling, or severe frontal headache.

HOW SUPPLIED: Mudrane and Mudrane GG available in bottles of 100 and 1000 tablets; Mudrane-2 and Mudrane GG-2 in 100s; Elixir in pints and half-gallons.

Federal law prohibits dispensing without prescription.

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MSMA

MISSOURI STATE MEDICAL ASSOCIATION

NEWS ROUND - UP

JUNE, 1975

Fee regulations challenged

Council opposes Manpower bill

Opposition to the Health Manpower bill before the U.S. House of Representatives and to Department of HEW regulations which would limit physician fees was expressed during the May meeting of the MSMA Council in Jefferson City.

It was pointed out that the Manpower bill would place control of the number and location of medical residencies with the Department of HEW and would require medical students to repay Federal capitation grants made to medical schools.

Dr. R. Allen Chandler, Kansas City, MSMA President, had expressed the Association's objections to the bill when it was in the House Interstate and Foreign Commerce Committee (May issue). However, the bill was passed by the Committee and will soon be on the House floor. Missouri's entire Congressional Delegation will be informed of the MSMA's opposition.

The HEW regulations as reported in the May MISSOURI MEDICINE, would tie physicians' fees to economic indices so that Medicare costs, "will follow, rather than lead, any inflationary trends."

The new formula returns the base period for reimbursement to 1973, a year in which the medical profession was under wage-price controls. The Council voted to protest the proposed regulations to HEW.

In other actions, the Council:

- Adopted a Resolution commending John A. Hailey for his 29 years of service to the medical profession as Executive Secretary of the State Board of Registration for the Healing Arts. Mr. Hailey retired effective June 1, 1975.

- Voted to send correspondence to each MSMA member regarding the current efforts being carried out by the Association in seeking answers to the professional liability insurance crisis.

- Encouraged the cooperation of the MSMA Woman's Auxiliary in expanding the statewide effort for Immunization Action Month.

- Reviewed the 29 Resolutions passed by the MSMA House of Delegates. Action on many of the Resolutions has already been taken as directed by the House. Informational Resolutions were referred to appropriate committees and commissions.

- Commended Gov. Christopher Bond for his statement in opposition to Public Law 93-641, the National Health Planning and Resource Development Act of 1974.

Malpractice hearings to begin in Kansas City

Missouri physicians will have the opportunity to present their views on the current professional liability insurance situation before various government groups this summer.

Officers of the MSMA and MSMI (Association's malpractice insurance firm) have already made plans to attend open hearings by the Senate Select Committee, the Governor's Task Force on Malpractice and a year unnamed House Committee.

The MSMA was intrumental in the establishment of the Senate Select Committee, chaired by Sen. Albert Spradling of Cape Girardeau. In addition, the Association is represented on the Governor's Task Force by Dr. Howard McAlhany, chairman of the MSMA Council.

Physicians in the Kansas City area will have the first opportunity to testify before the Senate Committee. The Committee will hold open hearings at the Plaza Inn on Wednesday, June 25, and Thursday, June 26. Wednesday's schedule is from 10 a.m. to 4 p.m. and Thursday's schedule is from 10 a.m. to 2 p.m.

Sen. Spradling has announced that the Committee will meet several times in various locations around the state. Notice will be published preceding the hearings. Other members of the Committee are Sens. William Cason, Clinton; Mary Gant; Kansas City; Richard Webster, Carthage; Paul Bradshaw, Springfield; and Harry Wiggins, Kansas City.

Medical News-in-Brief

Two MSMA tours planned

Two MSMA-sponsored tours are scheduled for this Fall.

The first tour is the "North to Alaska Cruise," September 15-25, with departure from St. Louis and Kansas City. The tour package includes round trip air transportation, eight days and nights aboard the luxury ship Sun Princess, five ports of call — Ketchikan, Juneau, Skagway, Glacier Bay and Sitka — and two days and nights in Vancouver, British Columbia.

MSMA members can choose accommodations from $999 to $1099.

The second MSMA-sponsored trip will be coordinated with the AMA's Clinical Convention, in Hawaii. Departure from Kansas City and St. Louis will be November 27 and 28.

Three programs will be offered: Program A — seven days in Hawaii; Program B — seven days and six nights visiting Honolulu and the islands of Hawaii and Maui; Program C — 13 days and 12 nights in Honolulu and on the islands of Kauai, Maui and Hawaii.

Additional information is available by telephoning or writing MSMA Headquarters.

MMPAC address change

Effective June 1, 1975, the address of the Missouri Political Action Committee (MMPAC) has been changed from P. O. Box 755, Jefferson City, Missouri 65101 TO:

MMPAC
P. O. Box 9338
St. Louis, Missouri 63117

Dr. Ritter Re-elected

Dr. Hubert A. Ritter, of St. Louis, was re-elected Chairman of the Missouri Medical Political Action Committee (MMPAC) at the committee's annual meeting in St. Louis.

Other officers elected were Dr. Donald K. Back, Springfield, Vice-Chairman; Mrs. James A. Reid, Marshall, Secretary; and Dr. E. J. Cunningham, Jr., St. Louis County, Treasurer. Dr. John N. Martin, St. Joseph, was appointed Assistant Treasurer.

The following members were elected to three-year terms on the Board of Trustees: District 2: Dr. J. Will Fleming, Moberly, and Dr. John F. Clisham, Hannibal; District 4: Dr. E. J. Cunningham, Jr., St. Louis County, and Dr. Louis P. Hetlage, Troy; District 6: Dr. Keith D. Jones, Warrensburg, and Mrs. James A. Reid, Marshall; District 8: Dr. Donald K. Back, Springfield, and Mrs. Michael Clarke, Springfield.

PSRO suit dismissed

A three-judge federal court in Chicago dismissed a suit challenging the constitutionality of Professional Standards Review Organizations (PSRO's).

The decision rejected the contention raised by the Association of American Physicians and Surgeons (AAPS) that PSRO deprived physicians of their right to practice and invade the privacy of potential patients.

MSMI response good

More than 500 applications for professional liability insurance coverage have been received by MSMI, Inc., in a little over a month since it began service.

MSMI is the malpractice insurance firm chartered by the Missouri State Medical Association at the direction of the House of Delegates.

James L. Hamilton, of Rollins Burdick Hunter Co., the broker for MSMI, said the initial reception of the company has been very satisfactory. He stated that the full MSMA membership will be sent an announcement of the company around June 15.

MSMA members desiring information on MSMI should either call Hamilton or Tim Danis of Rollins Burdick Hunter at (314) 241-8010 or write to the firm at 112 North 4th Street, St. Louis, Missouri 63102.

Dr. Cross heads Foundation

Dr. Albert D. Cross, of Trenton, was re-elected President of the Missouri State Medical Foundation at the organization's meeting in St. Louis.

Other officers elected to one-year terms were Dr. Kenneth C. Hollweg, Kansas City, Vice President, and Dr. Charles R. Doyle, St. Louis, Secretary-Treasurer. Dr. Max S. Franklin, St. Louis, was re-elected to a five-year term on the Board of Trustees.

Other members of the Foundation's Board are Dr. Miles C. Whitener, St. Louis County, and Dr. Robert H. Tanner, Jefferson City. MSMA President, Dr. R. Allen Chandler Kansas City, is an Ex-Officio member of the Board.

Records of the MSMA's student loan program showed that $79,000 was loaned to 142 students during 1974. Since the program was begun in September 1960, almost $600,000 in low-interest loans have been made to Missouri medical students.

Funds for the student loans are raised each year through a $10 assessment on MSMA members plus contributions and bequests from individuals, County Medical Societies and County Auxiliaries.

As has been the case for several years, the Clay County Auxiliary again led the way in contributions during 1974 with a donation of $830.

Other voluntary contributors included: Cole County Auxiliary, $367; Woman's Auxiliary to MSMA, $300; West Central Missouri Medical Society, $250; Grand River Medical Society, $200; Jackson County Auxiliary, $100; Greene County Auxiliary, $100; Dr. Albert D. Cross, $100; Dr. Max S. Franklin, $100; Dr. Doyle C. McCraw, $100. A total of $330 was received in contributions of under $100 each.

The Foundation's Board urged MSMA members to send voluntary contributions to the student loan program and to remember the Foundation in bequests.

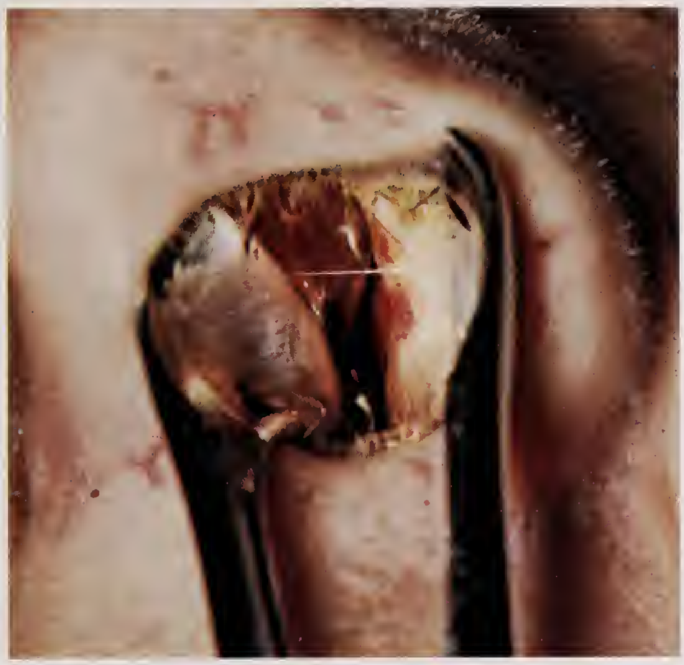
Dr. McCraw mentioned during the meeting that many patients ask their doctors if they know of good groups to leave money or to donate funds which will advance medicine. The education of physicians, it was pointed out, is perhaps the best way to increase and improve medical care.

Maybe the patient's self-diagnosis is right. He could have hay fever. But that bright red nasal mucosa, along with the thick discharge and excoriation around the nares, strongly suggests that the main problem is a cold. Hay fever or another form of allergic rhinitis may or may not be an underlying factor.

If a complete history and examination rule out allergic rhinitis, the long-term outlook will be a lot more favorable than his own "diagnosis" would have indicated.

But right now, whether he's got allergic rhinitis or a cold, he's suffering from the same irritating symptoms of drip, congestion and stuffiness. Try DIMETAPP EXTENTABS®. They're formulated to relieve these symptoms without much chance of causing drowsiness or overstimulation. Your patients will appreciate the 24-hour relief they can get from just one tablet every 12 hours.

Cold or



Allergy?

Whether it's a cold or an allergy, Dimetapp Extentabs® effectively relieve stuffiness, drip and congestion.

INDICATIONS: Dimetapp Extentabs are indicated for symptomatic relief of allergic manifestations of upper respiratory illnesses, such as the common cold, seasonal allergies, sinusitis, rhinitis, conjunctivitis and otitis. In these cases it quickly reduces inflammatory edema, nasal congestion and excessive upper respiratory secretions, thereby affording relief from nasal stuffiness and postnasal drip.
CONTRAINDICATIONS Hypersensitivity to antihistamines of the same chemical class. Dimetapp Extentabs are contraindicated during pregnancy and in children under 12 years of age. Because of its drying and thickening effect on the lower respiratory secretions, Dimetapp is not recommended in the treatment of bronchial asthma. Also, Dimetapp Extentabs are contraindicated in concurrent MAO inhibitor therapy.
WARNINGS: *Use in children:* In infants and children particularly, antihistamines in overdosage may produce convulsions and death.
PRECAUTIONS: Administer with care to patients with cardiac or peripheral vascular diseases or hypertension. Until the patient's response has been determined, he should be cautioned against engaging in operations requiring alertness such as driving an automobile, operating machinery, etc. Patients receiving antihistamines should be warned against possible additive effects with CNS depressants such as alcohol, hypnotics, sedatives, tranquilizers, etc.
ADVERSE REACTIONS: Adverse reactions to Dimetapp Extentabs may include hypersensitivity reactions such as rash, urticaria, leukopenia, agranulocytosis, and thrombocytopenia; drowsiness, lassitude, giddiness, dryness of the mucous membranes, tightness of the chest, thickening of bronchial secretions, urinary frequency and dysuria, palpitation, hypotension/hypertension, headache, faintness, dizziness, tinnitus, incoordination, visual disturbances, mydriasis, CNS-depressant and (less often) stimulant effect, anorexia, nausea, vomiting, diarrhea, constipation, and epigastric distress.
HOW SUPPLIED: Light blue Extentabs in bottles of 100 and 500.

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the analgesic formula that calms instead of caffeinates

Phenaphen® with Codeine

Phenaphen with Codeine No 2, 3, or 4 contains: Phenobarbital (¼ gr.), 16.2 mg. (warning: may be habit forming); Aspirin (2½ gr.), 162.0 mg.; Phenacetin (3 gr.), 194.0 mg.; Codeine phosphate, ¼ gr (No. 2), ½ gr. (No 3) or 1 gr (No. 4) (warning: may be habit forming)

Indications: Provides relief in severer grades of pain, on low codeine dosage, with minimal possibility of side effects. Its use frequently makes unnecessary the use of addicting narcotics. **Contraindications:** Hypersensitivity to any of the components. **Precautions:** As with all phenacetin-containing products, excessive or prolonged use should be avoided. **Side effects:** Side effects are uncommon, although nausea, constipation and drowsiness may occur. **Dosage:** Phenaphen No. 2 and No. 3—1 or 2 capsules every 3 to 4 hours as needed; Phenaphen No. 4—1 capsule every 3 to 4 hours as needed. For further details see product literature.

Ⓒ III Phenaphen with Codeine is now classified in Schedule III, Controlled Substances Act of 1970. Available on written or oral prescription and may be refilled 5 times within 6 months, unless restricted by state law.

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The cerebral or peripheral vascular disease patient often has coexisting disease[1] which calls for another drug along with his vasodilator. It may be a hypoglycemic, miotic, antihypertensive, diuretic, anticoagulant, corticosteroid, or coronary vasodilator.

Vasodilan is not incompatible with any of these drugs—no treatment conflict has been reported. And, unlike other vasodilators, Vasodilan has not been reported to affect carbohydrate metabolism, liver function, or intraocular pressure—or to complicate treatment of diabetes, hypertension, peptic ulcer, glaucoma, or liver disease.

In fact, there are no known contraindications to the use of Vasodilan in recommended oral doses, other than that it should not be given in the presence of frank arterial bleeding or immediately postpartum.

1. Gertler, M. M., et al.: Geriatrics *25*:134-148 (May) 1970.

Indications: Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows:

Possibly Effective:

1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.
3. Threatened abortion.

Final classification of the less-than-effective indications requires further investigation.

Composition: Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg.

Dosage and Administration: 10 to 20 mg. three or four times daily.

Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

Adverse Reactions: On rare occasions, oral administration of the drug has been associated in time with the occurrence of severe rash. When rash appears, the drug should be discontinued. Occasional overdosage effects such as transient palpitation or dizziness are usually controlled by reducing the dose.

Supplied: Tablets, 10 mg.—bottles of 100, 1000, 5000 and Unit Dose; 20 mg.—bottles of 100, 500 and Unit Dose.

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in Brief

A summary of AMA, medical & health news

American Medical Association / 535 North Dearborn Street / Chicago, Illinois 60610 / Phone (312) 527-1500 / TWX 910-221-0300

The AMA's new NHI plan—the Comprehensive Health Care Insurance Act—was introduced in Congress late in April. It builds on the existing structure of employer-employee group health insurance plans. Each employer would be mandated to provide comprehensive and catastrophic benefit coverage and pay at least 65% of the cost. Employees would not be compelled to participate. Under the plan, the self-employed and unemployed could purchase qualified private health insurance, with the government paying all or part of the premium, depending on income tax liability. Medicare beneficiaries could purchase supplemental insurance, with the government assisting people with limited incomes. Medicaid would be eliminated. Small businesses that would be burdened by the mandated plan would receive assistance from the government. State governments would regulate insurance subject to federal guidelines established by a 15-member Health Insurance Advisory Board.

AMA legislation to improve rural health care also was introduced in April. It would establish an Office of Rural Health within HEW to award grants, contracts, loans and loan guarantees for projects to examine existing models of care and to assist in planning, development and demonstration of rural health care delivery models. The bill authorizes $75 million for fiscal 1976, $100 million for fiscal 1977 and $125 million for fiscal 1978. An 11-member advisory committee would make recommendations on planning, policies and priorities to the HEW office.

"You, the Telephone Manager," is a telephone training program for medical office assistants offered to county medical societies through the AMA's Dept. of Practice Management. Each is arranged by the county society, which charges a minimum registration fee of $10-$15 to cover the cost of materials and the instructor's travel. For information, contact Department of Practice Management, AMA Headquarters.

AMA's third regional continuing medical education program goes to Minneapolis on July 26-27. It is presented in cooperation with the U. of Minnesota Medical School and the Minnesota State Medical Association. The fourth program is set for September 27-28 in Williamsburg, Va. For information, write to Department of Scientific Assembly, AMA Headquarters.

Effective on May 1, the AMA established a new Department of Negotiations in the division of Medical Practice. Initially, it will focus on two major functions—education of medical society personnel in the art and science of negotiation and development in the AMA of the capability to respond to select negotiation needs of the federation.

The number of HMOs in the U. S. is declining, according to InterStudy, a Minneapolis research organization. An April census showed 181 HMOs delivering care, two fewer than there were three months earlier. An InterStudy spokesman said the trend indicates the need for amendments to the federal law, particularly its elaborate benefit package.

Allied health committees in state and county medical societies will be listed in the next edition of the AMA's *Allied Medical Education Directory*. Directors of medical societies which have such committees are asked to send names and addresses of chairmen to Cora Benares, Department of Allied Medical Professions and Services, AMA Headquarters.

The National Association of Insurance Commissioners will establish a central data collection system on medical liability insurance. A serious roadblock to finding solutions to the nation's medical liability insurance problem has been a lack of data. Carriers will be required to provide the data in standardized form in their annual reports to state insurance commissioners, who will forward the information to NAIC headquarters in Milwaukee for tabulation.

medical melange

Notes of interest from Here .... and There

Dr. Robert H. Felix, dean emeritus of the St. Louis University School of Medicine and program coordinator of the Bi-State Regional Medical Program, has been named to the Society of Scholars at The Johns Hopkins University in Baltimore. The Society honors former postdoctoral fellows at Johns Hopkins who have distinguished themselves in their fields. Dr. Felix, a psychiatrist, founded the National Institute of Mental Health in 1946 and was its first director.

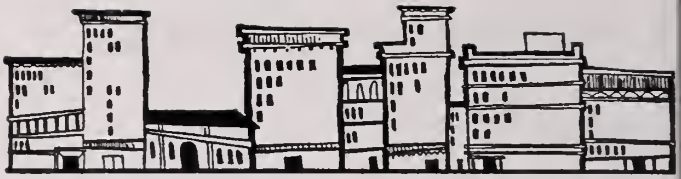
May 12-18 was proclaimed "**Dr. Thomas Wayland Week**" in Camdenton by **Mayor Ron Hulett.** A tea and reception honoring Dr. Wayland on May 18 was ponsored by the local Xi Delta Upsilon Chapter of Beta Sigma Phi, who selected him as their annual honoree in recognition of the many years he has served their community. Dr. Wayland moved from St. Louis to Camdenton 18 years ago at he age of 67. Now, at age 85, he is still practicing medicine in his office 40 hours each week. Many of his St. Louis patients still drive to Camdenton to see him. Xi Delta Upsilon is a social, cultural and service sorority.

Dr. C. V. Hammler, a long-time resident and physician at St. James, celebrated her 90th birthday with a special birthday dinner at the Elms Restaurant. Dr. Hammler is a native of Vandsburg, Germany. She received her M.D. degree from the National University of Arts and Sciences in St. Louis in 1914. She has lived in St. James since 1929.

Dr. John M. Boyce has been elected mayor of Mexico (Mo.).—**Dr. F. T. H'Doubler, Jr.**, Springfield, was the commencement speaker for Greenwood High School in Springfield on May 15.

Dr. Edward M. Grim of Joplin was the guest speaker at a meeting of the Fifth District Nurses Association in Joplin. Dr. Grim is an urologist.—**Dr. Kaye H. Kilburn,** director of the Division of Environment Medicine at the University of Missouri-Columbia, was the guest speaker at the 70th Anniversary luncheon meeting of the American Lung Association of Eastern Missouri at Stouffer's Riverfront Inn in St. Louis on May 12. His subject was "Tuberculosis in Missouri: Where Do We Go From Here?"

From the Medical Schools



ST. LOUIS UNIVERSITY

Groundbreaking ceremonies for the $2.5 million Ambulatory Care Center at St. Louis University Medical Center were held on April 25, 1975 on the south side of Vista Avenue west of Grand Boulevard.

Dr. George E. Thoma, vice-president for the Medical Center, presided at the ceremonies. *Dr. Edmund D. Pellegrino,* chairman of the board, Yale-New Haven Medical Center, was the principal speaker. Also attending were *Rev. Daniel C. O'Connell,* S.J., University president; *Mr. Daniel L. Schlafly,* chairman of the board of trustees; *Mr. Ben F. Jackson,* trustee committee chairman for the Medical Center; and *Mr. Richard L. Stensrud, Jr.,* director of the University Hospitals.

The three-story building will house the 26 specialty clinics now located in Firmin Desloge Hospital. The clinical physicians will combine both their private and clinical practices in the new building in an effort to consolidate services and facilities for the 36,000 patient visits per year to the Hospital clinics.

Breaking ground for the new Ambulatory Care Center at St. Louis University are *(from left)* Dr. George E. Thoma, vice-president for the Medical Center; John H. Poelker, mayor, City of St. Louis; and Frank C. Boland, alderman for the 17th Ward, City of St. Louis. The Bordley Memorial Pavilion, under construction, may be seen in the background.

The first floor of the structure will house radiology, laboratory, hemodialysis, pharmacy and optical shop services. Second and third floors will contain the 26 clinics and private offices for physicians. Construction is of masonry with bronze anodized solar glass.

A single parking deck with space for 253 vehicles will be constructed behind the Ambulatory Care Center.

Expected completion date is May, 1976.

Two faculty members, one alumnus, 19 senior students and six junior students of the St. Louis University School of Medicine were initiated into the University's chapter of Alpha Omega Alpha, a national honor society, on April 24.

New AΩA members attended a cocktail party and dinner at the Mansion House Center Alumni Club. Keynote speaker was *Dr. James Hitchcock,* professor of history, St. Louis University.

Faculty members initiated into the honor society were Medical Center vice-president *Dr. George E. Thoma* and *Dr. Garrett A. Hagen,* both associate professors of internal medicine. A 1973 alumnus, *Dr. James R. Etzkorn* of St. Louis, also was taken into the honor society.

Seniors honored were *Michael A. Borkowski, William F. Bradley, Dennis E. Bullard, Michael E. Burt, Terry L. Dwelle, Douglas L. Falls, Hugh L. Flanagan, Ronald J. Gould, Phillip H. Hoffman* of St. Louis, *John A. Intravia, Alan P. Knutsen, Thomas R. Kovaric, Jeffrey M. Lipton, Miss Laurene Mascola, Lawrence R. McBride, James D. McGovern, Stephen J. Pandol, Miss Martha A. Reed* and *F. Stephen Wignall.*

Juniors taken into AΩA were *Gary R. Dibble, Corey H. Evans, Richard J. Herold, Michael I. Hutchinson, Gary M. Lamps* and *Dan A. Pardini.*

Conferral of keys was made by Alpha Omega

Alpha president, *Dr. Lawrence A. Solberg, Jr.* Membership is based on scholarship, character and personality.

WASHINGTON UNIVERSITY

Dr. Arthur E. Baue, Harry Edison Professor of Surgery at the School of Medicine and surgeon-in-chief at Jewish Hospital in St. Louis, will leave Washington University to head the Department of Surgery at Yale Medical School, starting in September.

Dr. Alexander Geha, Associate Professor at the School of Medicine and director of thoracic and cardiovascular surgery at Jewish Hospital, also will move to Yale Medical School.

Dr. Baue has directed the clinical, teaching and research activities at Jewish Hospital's Waldheim Department of Surgery since 1968. He previously taught at the University of Pennsylvania.

A noted expert on trauma or accidental injury, Dr. Baue's recent research has centered on a high-energy phosphate compound, ATP. He has been exploring the possible use of ATP injections to save patients who have gone into shock or whose circulation has failed completely as a result of surgery or injuries.

Dr. Geha has worked closely with Dr. Baue in the laboratory and is known for his expertise in coronary bypass surgery, using an artery.

Scientists at the Washington University School of Engineering and Applied Science and the School of Medicine have received nearly half a million dollars from the National Heart and Lung Institute for a three-year study of artificial heart valves.

Richard E. Clark, M.D., associate professor of urgery, is chief investigator for the $473,697 grant on "Advanced Cardiac Valvular and Vascular Prostheses."

"These leaflet valves will be flexible. We want o make sure they can endure before we implant hem in animals. Presently, we are a long way from using them in humans," Dr. Clark said.

The group working on the project includes surgeons, engineers (chemical, mechanical and civil) nd technicians. They are continuing to test a new rileaflet prosthetic aortic valve and will study the tress distribution and mechanical properties of ricuspid and mitral valves. Part of the work will be done in heart-valve machines which correlate ata from simulated heart action. Other biochemcal testing of the polyester valves will apply information on the reaction between the blood and the materials in an effort to develop a substitute for very small arteries (3 multimeters in diameter).

The Washington University Medical School Alumni Association has honored *Mildred Trotter*, Ph.D., a member of the faculty for 55 years, by endowing a lecturership in her name.

Dr. Trotter, professor emeritus and lecturer in the Department of Anatomy and Neurobiology since 1967, is the first woman faculty member to be recognized in this way. Each year, a distinguished woman scientist will be brought to the University to give the Mildred Trotter Lecture. In addition, a portrait of Dr. Trotter by St. Louis artist, Aimée Schweig, will be hung at the Medical Center.

Dr. Trotter's dynamic contributions as a teacher and her reputation as a scientist in the field of anatomy and physical anthropology have earned many honors for her in the past.

Samuel B. Guze, M.D., vice-chancellor for Medical Affairs and head of the Department of Psychiatry, said: "Our Medical School has had truly memorable teachers who have left a lasting imprint on their students. For 55 years, Mildred Trotter has been one of these: Challenging, sparkling, incisive, always sympathetic and interested."

UNIVERSITY OF MISSOURI-COLUMBIA

Dr. Edward J. Beattie Jr., chief executive officer at Memorial Hospital in New York City and professor of surgery at Cornell University Medical College, delivered this year's W. Alton Jones Lecture on problem cases in cancer.

Dr. Beattie, a thoracic surgeon, is another addition to a prestigious group of physicians who have been invited to speak at the UMC Medical Center since the W. Alton Jones Distinguished Professorship was established in 1967. The academic chair honors the man whose family set up a Foundation in his name to support medical education.

The chair is now occupied by *Dr. Donald Silver*, chairman of the Department of Surgery, who came to Missouri from Duke University in February 1975. The first distinguished professor of surgery was *Dr. Marion S. DeWeese*.

The graduating Class of 1975 numbered 105. Pre-commencement guest speaker was *Dr. Robert Q. Marston*, now president of the University of Florida-Gainesville who was director of the National Institutes of Health, 1968-1973. *Dr. John L. Winnacker*, associate professor of medicine, was selected by the graduates to be the speaker at the Senior Banquet which followed the pre-commencement program.

Student honors went to *Dr. Ronald H. Hodges* of

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For More Information, Contact
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Independence, selected for the Doctor's Day Award given by the *Women's Auxiliary of the Boone County Medical Society* and also the Fred B. Kyger Jr. Award in Obstetrics/Gynecology and *Drs. Gregg Galloway*, Chesterfield, and *Michael Hagen*, St. Louis, who shared the Student Leadership Award.

Dr. Craig L. Humphries, Kansas City, received the *Missouri State Medical Association's* award to an outstanding senior and the Department of Child Health Award; *Dr. John Onofrio*, Columbia, the Upjohn Award for outstanding achievement in academic and clinical proficiency; *Dr. Emily Militzer*, Altenburg, the Radiology Department Award; *Dr. Eric Carlson*, Creve Coeur, the awards given by the Departments of Surgery and Psychiatry; *Dr. Edwin A. Bowe*, Jefferson City, the Parker B. Francis Award in Anesthesiology; *Dr. Sam Cullison*, St. Louis, and *Dr. William E. Wilson*, Columbia, the Family Practice Award; *Dr. Dan Longo*, St. Louis, the Department of Internal Medicine Award.

The Spring Honors Convocation featured an address by *Dr. C. Barber Mueller*, professor of surgery at McMasters University, Hamilton, Ont. The event sponsored by Alpha Omega Alpha honors *Dr. Milton D. Overholser*, professor emeritus of anatomy. New members elected to AOA included *Dr. Daniel Winship*, professor of medicine and chief of gastroenterology.

Dr. David Davis, professor of psychiatry, has been elected president of the *Missouri Psychiatric Association*. *Dr. Thomas Burns*, professor of medicine, was installed as governor of the *Missouri chapter, American College of Physicians* at the annual meeting in April. *Dr. Hugh Stephenson*, professor of surgery, completes a term in June as president of the *Missouri chapter, American College of Surgeons*.

UNIVERSITY OF MISSOURI-KANSAS CITY

Of the 22 students who graduated from the School of Medicine on May 10, 14 have entered residency positions in the Greater Kansas City Area. Seventeen of these 22 graduates have entered primary care residency programs.

The School of Medicine has now graduated a total of 34 graduates since 1973. Twenty of these graduates are located in Missouri and the metropolitan Kansas City region. Two of these graduates, both of whom are oral surgeons, have entered practice. All of the remaining 32 graduates are in residency programs affiliated with Universities, several of which are in University hospitals. Nineteen of the 34 total graduates have entered residency programs in Missouri and the Kansas City area.

The post-T & A patient:

another type for TYLENOL® acetaminophen products

When the post-T & A patient requires an analgesic, a new problem arises. Hemorrhagic tendencies following the use of aspirin after tonsillectomies have been reported.[1,2] In a patient who "...has recently undergone a surgical procedure or has another underlying hemostatic defect, aspirin ingestion may cause significant bleeding.... Aspirin is absolutely contraindicated in such situations. Acetaminophen...could replace aspirin in these instances."[3]

The post-T & A patient is only one of several 'types for TYLENOL' antipyretic-analgesic products—that is, patients who should avoid aspirin. Considering *all* of them, wouldn't it provide added safety (as well as added convenience) to recommend TYLENOL products routinely for simple analgesia?

References: **1.** Reuter, S.H., and Montgomery, W.W.: Arch. Otolaryng. *80*:214-217 (Aug.) 1964. **2.** Osol, A., et al., ed.: The United States Dispensatory and Physicians' Pharmacology, ed. 26, Philadelphia, J.B. Lippincott Co., 1967, p. 171. **3.** Schwartz, A.D., and Pearson, H.A.: J. Pediat. *78*:558-560 (March) 1971.

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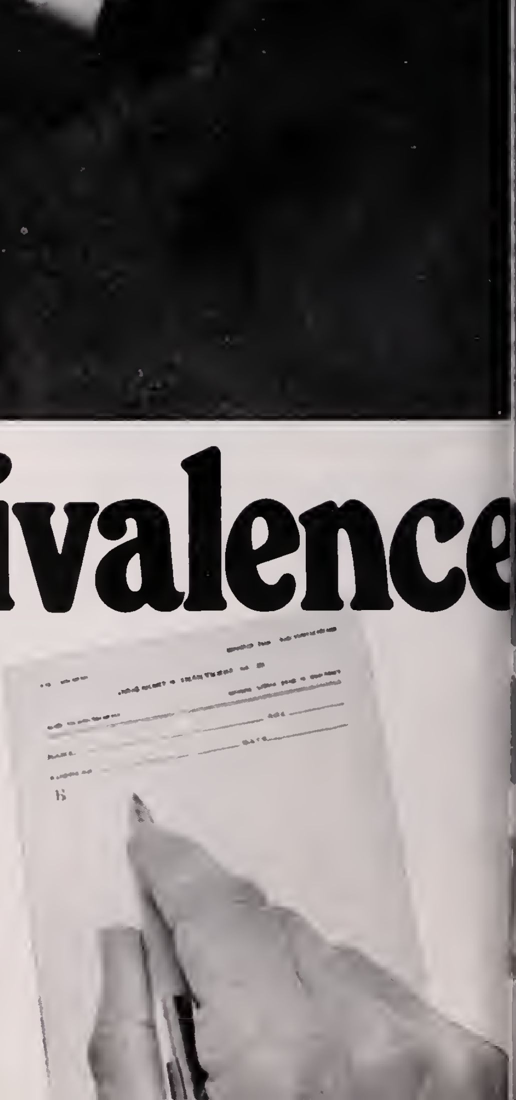
Bioequivalence



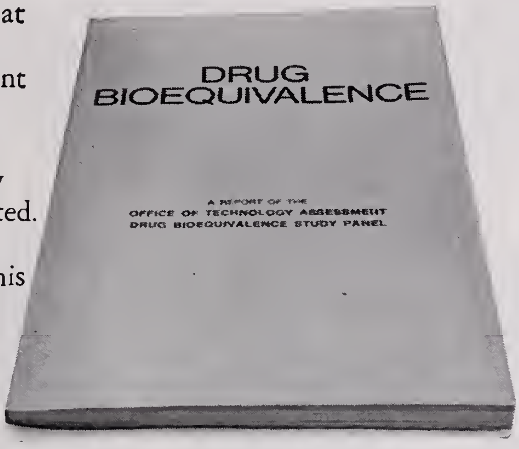
he weight of scientific opinion:

If the pharmacist substituted a hemically equivalent drug for the ne you have specified for your atient—could you be certain of that roduct's safety and effectiveness mply because the chemical content as the same?

Definitely not, unless bio- quivalence tests and other quality surance checks had been conducted. he pharmaceutical industry and any scientists have maintained this sition for years, but others have uestioned it. Now the Office of chnology Assessment of the ongress of the United States has ported on the issue in its Drug ioequivalence Study.*

Here are a few definitive state- ents in the O.T.A. report:

"…the problem of bioinequiva- ncy in chemically equivalent prod- ts is a real one. Since the studies in hich lack of bioequivalence was monstrated involved marketed oducts that met current compen- al standards, these documented in- ances constitute unequivocal idence that neither the present andards for testing the finished oduct nor the specifications for aterials, manufacturing process, d controls are adequate to ensure that ostensibly equivalent drug products are, in fact, equivalent in bioavailability.


DRUG BIOEQUIVALENCE
A REPORT OF THE OFFICE OF TECHNOLOGY ASSESSMENT DRUG BIOEQUIVALENCE STUDY PANEL

"While these therapeutic failures resulting from problems of bioavailability were recognized and well documented, it is entirely possible that other therapeutic failures and/or instances of toxicity that had a similar basis have escaped attention."

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(b) biological equivalence, where bioavailability test methods have been validated as a reliable means of assuring clinical equivalence; or

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In addition, the PMA supports federal legislation that would require certification of all manufacturers of prescription products before they could start in business, annual inspections and certification thereafter, and strict adherence to FDA regulations on good manufacturing practices.

The overall quality of the United States drug supply is excellent. But only a total quality assurance program, envisaged in these and other policy positions adopted by the PMA Board of Directors in 1974, can bring about acceptable levels of performance by all prescription drug manufacturers and thereby assure the integrity of your prescription…

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WILLIAM J. OTT, M.D., FRANK OSTAPOWICZ, M.D.
and RALPH E. WOODS, M.D., *St. Louis*

Ectopic Pregnancy After Laparoscopic Tubal Electrocauterization for Sterilization

Case Report

INCE THE EARLY 1960s, when Steptoe[1, 2] in Great ritain described the techniques of laparoscopic ubal sterilization, the use of the laparascope for terilization has gained wide acceptance in Europe nd the United States. It is estimated that more han 100,000[3] procedures are done each year in the nited States. Siegler,[3] in an excellent review of he uses of laparoscopy in gynecology, has listed nany of the complications associated with this proedure and has stated that the efficacy of the procelure is still uncertain.

A number of reports of pregnancy after laparocopic sterilization have appeared in the literature n recent years.[4–11] Most of these have been intraterine, but a few cases of ectopic pregnancy have een reported.[12]

The following report is of a case of ectopic regnancy following laparoscopic tubal electrocauerization for sterilization.

ASE REPORT

A 23-year-old white woman, gravida 3, para 2, vas admitted to the St. Louis City Hospital on Sept. 6, 1973 at 9 AM with a 16-hour history of lower bdominal pain and pressure symptoms localized in he suprapubic area. Her last menstrual period was n mid-August, 1973. The patient gave the history f an elective laparoscopic tubal sterilization on pril 4, 1973 in California, but no subsequent hyserosalpingogram was done. According to the operative report, ". . . the tubes were coagulated one inch from their insertion into the uterus and then cutting current applied and a portion of the tubes removed." No pathology report was available.

The rest of the patient's past history and family history were essentially noncontributory to the present illness.

Physical examination on admission revealed a temperature of 98.6 F, pulse rate of 82 per minute, respiration rate of 28 per minute and blood pressure of 110/70 mm of Hg. Pertinent physical findings were limited to the abdomen, which showed marked direct tenderness in both lower quadrants and in the suprapubic area, slight rebound tenderness and hypoactive bowel sounds. There was voluntary guarding but no rigidity. No evidence of shock or shoulder pain was present.

Pelvic examination revealed normal female external genitalia. Speculum examination revealed a pink, slightly hypertrophied cervix with a thick whitish discharge. No lesions or blood were seen. The cervical os was closed. Bimanual examination revealed extreme tenderness in both quadrants when the cervix was moved. The uterus was difficult to evaluate because of voluntary guarding, but the size appeared to be within normal limits. The recto-vaginal examination revealed no masses in the cul de sac. A culdocentesis was attempted but no fluid was obtained after two attempts.

The initial impression was that of an acute abdominal pain of uncertain etiology to rule out (1) ruptured ovarian cyst or torsion of an ovarian cyst, (2) pelvic inflammatory disease, (3) acute appendicitis, (4) ectopic pregnancy.

According to the literature, the incidence of ectopic pregnancy following laparoscopic tubal sterilization is only 0.07%. This possibility should be kept in mind, however, and the appropriate diagnostic procedures should be carried out for the patient with abdominal pain, a history of amenorrhea and irregular vaginal bleeding. The authors are from the Department of Gynecology and Obstetrics, St. Louis University School of Medicine, where Dr. Ostapowicz and Dr. Woods are associate professors.

Admission blood studies showed the following values: hematocrit reading, 35%; hemoglobin, 12.9 gm/100 ml; white blood cell count 11,700/cu mm with 83 segs, 14 lymphocytes, 2 monocytes and 1 stab. Electrolytes were sodium, 139 mEq per ml, 108 mEq per ml of chloride, 4.2 mEq per ml of potassium and bicarbonate 24 mEq per ml. Urinalysis was within normal limits.

The patient was started on bed rest with a regimen of intravenous fluids. Prognosticon pregnancy test was positive twice, but tests run against non pregnant controls were also read as positive. Seven hour after admission, the patient stated that her abdominal pain had decreased, but she began to complain of pain in the left shoulder. Vital signs remained stable and the patient's temperature was 99.2 F. Flat plate and upright X-ray views of the abdomen were obtained and interpreted as within normal limits. A repeat blood count at 10 PM showed a hematocrit reading of 32%, hemoglobin value of 11.6 mg/100 ml and a white blood count of 11,500 per cu mm.

The patient was reevaluated 23 hours after admission with essentially the same physical findings. An HCG pregnancy test was reported as positive. A repeat blood count at this time showed the following: hematocrit reading, 28%; hemoglobin level, 9.8 gm/100 ml; white blood count, 7200 per cu mm. It was decided to take the patient to the operating room for a pelvic examination under general anesthesia and to repeat the culdocentesis and perform a laparoscopy or laparotomy.

At 1 PM on Sept. 27, 1973, a pelvic examination was done with the patient under general anesthesia. It revealed an ill-defined, boggy mass in the left adnexal region. Culdocentesis obtained 1 ml of dark blood which did not clot. An exploratory laparotomy was done through a Pfannenstiel incision and approximately 300 ml to 400 ml of old blood and clots were found in the abdominal cavity. Examination of the pelvic contents showed a normal sized uterus. The right tube showed evidence of the previous tubal cauterization approximately one inch from the cornu of the uterus with complete separation of the two portions of the transected tube. The left adnexa showed a cystic, ovoid mass in the ampullary portion of the tube with active bleeding. No previous tubal ligation site was evident, but the round ligament was completely normal.

A left salpingo-oophorectomy and partial right salpingectomy were done. The pathological diagnosis of the specimens were as follows:

1. Right Fallopian Tube: Partial salpingectomy without pathological diagnosis.
2. Left Fallopian Tube: "With evidence of ectopic pregnancy. . . . Lumen filled with blood clot and fibrin, containing a small number of immature chorionic villi and trophoblasts, involving the wall of the tube, partly to the subserosal area."
3. Left Ovary: Corpus Luteum.

The patient's postoperative course was essentially unremarkable and she was discharged on the sixth postoperative day.

DISCUSSION

The incidence of ectopic pregnancy has variously been stated as one in 40[13] to one in 303[14] pregnancies. Various causes for ectopic pregnancies have been stated, and Breen[15] has made an excellent review of the subject. A previous tubal ligation seems to be associated only with ectopic pregnancy in very few instances, accounting for only 0.6% of all ectopic pregnancies. With the rising incidence of laparoscopic tubal electrocauterization, there may be expected to be a rising number of ectopic pregnancies associated with this procedure.

The failure rate of tubal ligation after the Pomery method has been estimated as 0.25% to 2%[16] and a small proportion of these failures account for some of the ectopic pregnancies. The exact failure rate for laparoscopic tubal sterilization is uncertain, but various authors[4–11] have reported the incidence of both intrauterine and ectopic pregnancies after this procedure. Table 1 shows the results following more than 8,000 cases of laparoscopic tubal ligation. The incidence of intrauterine pregnancy, excluding those pregnancies that were thought to have occurred prior to the procedure, was 0.31%. The incidence of ectopic pregnancy was 0.07%.

Table 2 shows the results of various studies[4, 6, 8, 10] done to detect persistent tubal patency after tubal electrocauterization. Two interesting conclusions are apparent from these studies: (1) When hysterosalpingography was done within six weeks after the procedure, 35% of the patients showed evidence of tubal patency, and (2) the incidence of patent tubes as delineated by hysterosalpingogra-

TABLE 1

uthor	# of Patients	Pregnancies INTRAUTERINE	ECTOPIC
ordan *et al*[1]	910	1 (0.1%)	0
hompson & Wheeless[5]	3,600	12 (0.6%)*	0
eith *et al*[6]	172	1 (0.4%)	0
aynes & Wolfe[7]	790	7 (1%)	3 (0.4%)
lack[8]	300	1 (0.3%)	1 (0.3%)
iston *et al*[9]	760	9 (1%)	0
eterson & Behrman[10]	200	1 (0.5%)	0
teptoe[11]	1,350	0	2 (0.02%)
otal	8,092	32 (0.31%)	6 (0.07%)

* Not including 12 patients who were thought to be pregnant prior to the procedure.

hy (excluding those cases done within six weeks f the procedure) is 2%.

Table 3 shows the results of a study of Wheeless and Thompson[5] at Johns Hopkins University from 1968 to 1972. They related the incidence of intrauterine pregnancy after laparoscopic tubal electrocauterization of 3,600 patients to the exact techniques used for the procedure. The lowest incidence of subsequent pregnancy was after a "three burn" technique.

There also were four pregnancies which resulted from inadvertent electrocauterization of the round ligament.

Failure of the technique to secure permanent tubal occlusion seems to be related to either inexperience or ineffectiveness of the "single burn" technique to cause complete occlusion of the tube.

In most cases after a failure of laparoscopic sterilization, conception results in normal intrauterine pregnancy. However, abnormal implantation, probably in the previously cauterized segment of the tube, can result in an ectopic pregnancy.

Ectopic pregnancy accounts for 6% to 6.5% of all maternal mortality in the United States.[15] Although ectopic pregnancy following laparoscopic tubal sterilization is uncommon, the possibility must always be kept in mind when dealing with a patient in the reproductive-age group who exhibits the triad of abdominal pain, amenorrhea and irregular bleeding despite a previous history of tubal sterilization.

Whether hysterographic examination to demonstrate patency should be routinely advised is debatable in view of the infrequent occurrence of pregnancy after the laparoscopic sterilization procedure.

TABLE 2

Author	*# of Patients Having Electro-cauterization*	*# of Patients Having Hystero-salpingography*	*# of Patients With Tubal Patency*
Peterson and Behrman[10]	200	50*	1 (2%)
Black[8]	300	120	3 (2.5%)
Keith *et al*[6]	172	25	0
Jordan *et al*[1]	910	386†	8 (2.5%)
		60‡	22 (35%)
Total	1,582	578§	11 (2%)§

* Followed between 12 weeks and 12 months.

† Done at 12 weeks after electrocauterization.

‡ Done at six week after electrocauterization.

§ Excluding the 60 patients done at six weeks after electrocauterization.

TABLE 3

CAUSES OF PREGNANCY AFTER LAPAROSCOPIC TUBAL ELECTROCAUTERIZATION

*Group**	*# of Patients*	*# of Subsequent Pregnancies*†
I	1,000	1
II	1,000	6
III	1,600	0

* Surgical Technique: group I—one burn, group II—one burn plus excision of portion of tube, group III—three burns.

† Intrauterine.

SUMMARY

A case of ectopic pregnancy following laparoscopic tubal sterilization has been presented. The incidence of ectopic pregnancy following laparoscopic tubal sterilization, as deduced from a review of the current literature is only 0.07%. However, this possibility should be kept in mind with any patient with abdominal pain, a history of amenorrhea and irregular vaginal bleeding, and the appropriate diagnostic procedures should be carried out.

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(Continued on page 290)

JOHN E. CODD, M.D., ***St. Louis***

Postoperative Pulmonary Complications

A Review

Despite advances in anesthesia and surgical management, postoperative pulmonary complications continue to be a major source of morbidity and mortality. The reported frequency of these complications range from 1.2% to 43.5% depending on the criteria used and the type of operative procedure reviewed. It is generally accepted that pulmonary complications occur in 10% to 20% of general surgical patients.[1, 2] It is common to expect a decrease in ventilatory reserve in patients undergoing thoracic surgical operations. However, the loss of ventilatory reserve associated with upper abdominal surgical procedures, nonthoracic trauma and infection have not received adequate attention.

As can be seen from Fig. 1, the ventilation, circulation and tissue metabolisms are not separate entities. Anscombe[3] and Latimer[4] studied various parameters of ventilatory function following abdominal operative procedures and found that conventional uncomplicated gastrectomy was associated with a 50% reduction in pulmonary functions during the first 48 hours postoperatively. The demands of tissue metabolism may be greatly accentuated by fever, infection or peritonitis and coupled with the initial loss of reserve, ventilatory failure may ensue.

The concept that operation or anesthesia carries substantial risk that can be qualified is outmoded. The anesthesiologist can maintain almost any patient through an operative procedure, but it is in the postoperative period where underlying chest disease of the patient is unmasked and respiratory insufficiency and failure develop. Clinical studies have shown that the majority of pulmonary complications occur in patients with impaired pulmonary function preoperatively.[4, 5] Prevention of these complications begins in the preoperative period. The recognition of the potential problem-patient by specific questioning concerning cigarette consumption, history of asthma, wheezing or dyspnea is important. The presence of advanced age, obesity or chest wall deformity or symptoms and signs of chronic bronchitis, and emphysema must be evaluated thoroughly preoperatively.

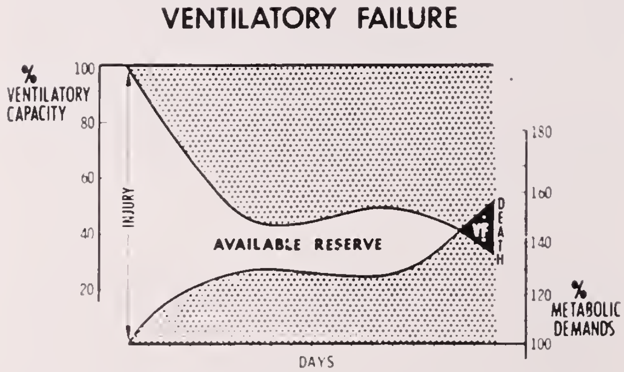
VENTILATORY FAILURE

Fig. 1 Available ventilatory reserve may be progressively narrowed at which time ventilatory failure ensues.

A patient who is about to have a general anesthetic and in whom there is a question of ventilatory insufficiency should undergo pulmonary function tests. The most frequently used tests have been the vital capacity, the forced-expiratory volume and the maximum-breathing capacity. If an operation is required, a patient who expels less than 50% of his vital capacity in one second or whose maximum breathing capacity is less than 50% of the predicted normal is a candidate for preoperative therapy and should be considered for possible postoperative support.[1, 4, 5] Preoperative therapy in such patients will include the use of expectorants, bronchodilators, mucolytic agents, postural drainage and breathing exercise. Sputum should be collected for culture and sensitivity if the patient raises more than a few milliliters per day. Preoperative blood gas analysis is advisable in any patient with significant pulmonary impairment.

Immediate respiratory complications are largely exaggerated side effects of anesthesia and operation. A period of respiratory depression is frequently seen in the immediate postoperative period. This may lead to upper-airway obstruction, but, more frequently, to hypoventilation and hypoxia.

Airway obstruction. Pharyngeal obstruction secondary to accumulated secretions or the tongue falling back into the pharynx is relatively common and is easily relieved by placement of an oral-pharyngeal airway. A rare but more difficult problem to deal with is that of laryngeal spasm following intubation. "Crowing" respiration with evidence of intercostal retraction is obvious. This condition frequently requires tracheal intubation.

Hypoventilation is a product of the prolonged effect of anesthetic sedation and relaxant drugs. Treatment is usually that of assisted ventilation and administration of antidote if available. The recognition of hypoventilation, however, may be difficult. Frequently, the patient is confused, noisy and hypertensive and is often treated with medication for apprehension and pain, thereby compounding the problem. Severely depressed respiratory rates are easily noticed, but a decrease in tidal volume is more difficult to recognize. Hypoventilation produces hypoxia, hypercarbia and acidosis. Hypoxia and acidosis lead to myocardial irritabilty and possible cardiac arrest secondary to ventricular fibrillation. Therefore, oxygen should be administered if there is any doubt in the adequacy of ventilation.[6] The diagnosis of hypoventilation can be substantiated by measuring the arterial blood gasses with pCO_2 above 55 mm of mercury or tidal volume under 400 cc. If there is any question about the ability of the patient to adequately ventilate, he should receive mechanical support until he is alert, awake and can maintain adequate ventilation. Hypoventilation may be related to other factors limiting respiratory volume such as bowel distention, restrictive dressings, exhaustion and decreased lung compliance which, at times, may respond to hyperinflation of the lung but probably will require ventilatory support with a mechanical ventilator.

Aspiration. Massive aspiration of gastric conents leads to a severe chemical pneumonitis and s associated with a mortality rate of 50% to 70%.[7] Treatment of aspiration pneumonitis consists of pulmonary lavage, bronchoscopy, massive doses of teroids and antibiotics plus respiratory support. Cameron and Zuidema[7] have demonstrated that occult aspiration is common and a probable cause of pathology in patients with tracheostomies and vicims of trauma. Aspiration pneumonitis is best prevented, and all allied personnel must be aware of the problem and institute those routine maneuvers such as care of nasogastric tube, proper poitioning of the comatose patient and meticulous are of the tracheostomy which are easily overooked in daily routine.

Atelectasis—pneumonia. Atelectasis is the most ommon postoperative respiratory complication. It s primarily due to collapse of the pulmonary parnchyma.[8] Early evidence of atelectasis is a temperature elevation associated with bronchial breath sounds. These physical findings usually occur before x-ray changes. Prevention of atelectasis is obtained by maintaining a clear tracheobronchial tree by deep breathing, frequent coughing and change of position along with an adequate narcotic to relieve pain. Should these steps be inadequate, endotracheal suction with nasopharyngeal catheter is required. A useful maneuver is percutaneous insertion of a plastic catheter into the upper trachea with frequent injections of saline to stimulate the cough and help liquify secretions. If these methods are not satisfactory, bronchoscopy will be needed. Pneumonia is a further extension of atelectasis with secondary infection of the collapsed lung area and should be treated with vigorous endotracheal toilet and appropriate antibiotics. Lung abscess is an extension of the pneumonic process with cavitation necrosis of the pulmonary parenchyma. This complication is frequently secondary to aspiration. Treatment, again, consists of postural drainage, endotracheal toilet and appropriate antibiotics. Fortunately, postoperative lung abscesses are rare and usually clear satisfactorily with an adequate medical regimen.

Prevention of postoperatve pulmonary complications which can lead to respiratory failure begins in the preoperative period. The ever-increasing number of patients with ventilatory insufficiency requires an increased ability on the part of medical personnel to recognize and preoperatively prepare them for operation. Dr. Codd is Chief, Unit II Surgery Service, Veterans Administration Hospital and Associate Professor of Surgery, St. Louis University School of Medicine.

Pulmonary edema. Pulmonary edema in the postoperative period is not a true respiratory complication as it is most often due to cardiac failure, but it can result from anoxia coupled with volume overload, usually overtransfusion. It usually responds to the usual cardiac regimen consisting of high O_2 concentration, diuretics, digitalis and cardiotonic drugs, but frequently required rapid removal of edema fluid from the tracheobronchial tree by suctioning through endotracheal or tracheostomy tubes. It should be remembered that pulmonary edema from volume overload may occur despite a normal venous pressure.[9–11] In the critically ill patient, a more adequate representation of volume replacement and left heart function can be obtained by a Swan-Ganz[12] catheter inserted into the pulmonary artery via venous cut-down or subclavian venous cannulization. In this manner, the reflection of the status of the cardiovascular system in the critically ill patient can be obtained.

Pulmonary emboli. Massive pulmonary embolus is a dramatic respiratory complication associated with severe dyspnea and hypoxia and is frequently followed shortly by cardiac arrest. Recognition of this disaster is of utmost importance to assure the institution of appropriate heparin anticoagulation.[13–15] Of equal importance is prevention of pulmonary emboli by early ambulation and anti-embolus stockings. Recently, several studies have indicated that the use of "mini-dose" heparin in the high-risk category has been successful in decreasing the instance of venous thrombosis of the lower extremity and possibly subsequent pulmonary emboli.[16–18]

Progressive pulmonary insufficiency. Progressive pulmonary insufficiency is a syndrome usually seen in the first 24 to 48 hours after a serious operation. Characteristically, the patient has had a history of previous pulmonary or cardiac illness. Dyspnea and tachycardia with grunting respiration mark the onset of the respiratory distress syndrome. Cyanosis is marked and frequently does not respond to the administration of oxygen. Auscultatory findings are minimal in the early stages. As the illness progresses, bronchial breath sounds are heard. Fine bubbling rales seen in congestive heart failure are not the feature of this illness. Roentgenographically, the first findings are patchy alveolar infiltrate which become coalescent as the illness progresses. Hypoxemia is manifested by a marked decrease in the arterial PO_2. Treatment of this entity consists of prevention or treatment of circulatory failure, limitation of fluid administration, use of mechanical ventilator to provide arterial oxygenation and elimination of CO_2, protection of the airway by the use of high-volume, low-pressure cuffed endotracheal or tracheostomy tubes and treatment of associated infection.[19–22] In those patients receiving large volumes of blood, effective prevention of small emboli has been demonstrated with use of commercially available 40μ blood filters.[23] Despite intense supportive therapy, the mortality rate for this syndrome remains in the range of 50%. With severe hypoxia, partial cardio-pulmonary bypass using a membrane oxygenator to support the patient with this complication has been attempted, but, thus far, only an occasional patient has been salvaged.

Subsequent infection. The appearance of the Surgical Intensive Care Unit in hospitals has been associated with the implementation of highly effective pulmonary support for patients who otherwise would have expired from the complications of respiratory failure. The use of this respiratory support is associated with a significant increase in respiratory infections which may counterbalance many of the benefits. It is apparent that several factors are critical in most patients requiring prolonged postoperative support. These factors consist in the high density of very critically ill patients in the Intensive Care Unit and the size of the unit which may predispose to infection. Indigenous use of inappropriate antibiotics frequently leads to serious respiratory tract complications. These seriously ill patients are frequently maintained under relatively broad-spectrum antibiotics whose effectiveness often exclude the gram-negative organisms of the Pseudomonas and Proteus genera. Again, careful, meticulous postoperative care of the patient on respiratory support to prevent aspiration or potential contamination is extremely important. Frequent cultures of secretions and appropriate selection of antibiotics is essential. Recently, the use of polyvalent pseudomonas vaccines has been studied, and these agents are being evaluated due to the high incidence of Pseudomonas infection.[24]

SUMMARY

The ever-increasing number of patients with ventilatory insufficiency who are now coming to surgery requires an increased ability on the part of medical personnel to recognize and preoperatively prepare these patients for operation. Pulmonary complications can lead to respiratory failure, the treatment of which may be extremely difficult. The training of the staff equipped to handle respiratory problems is essential for good postoperative care.

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(Continued on page 290)

EDMUND HO, M.D. *and* **DONALD J. MEHAN, M.D.,** ***St. Louis***

Serum Acid Phosphatase Levels in Untreated Carcinoma Patients

This study is presented to remind the practicing physician again that determining a normal serum acid phosphatase in a patient does not exclude the possibility of a carcinoma of the prostate. The authors are from the Department of Urology, St. Louis University School of Medicine.

IN 1935, Kutscher and Wolbergs reported high phosphatase activity in acid solution of human semen and of extracts of human prostatic tissue. In 1939, Gutman and Gutman noted that elevated acid phosphatase activity was found consistently enough to suspect the diagnosis of carcinoma of he prostate. Since then, this enzyme has been used o help establish the diagnosis of prostatic carcinoma. In prostatic cancer, however, the serum acid phosphatase may not be elevated, even in the face of proven metastasis. On the other hand, elevated phosphatase may not mean distant metastasis.

MATERIAL AND METHODS

Records of patients with a diagnosis of carcinoma of the prostate who were admitted to St. Mary's Hospital were reviewed. St. Mary's is a general hospital admitting about 80 patients yearly with a diagnosis of prostatic cancer. Patients who had been treated previously for their cancer were excluded from the study. One hundred consecutive patients with their initial diagnosis of prostatic cancer were chosen for this study. Staging was done retrospectively according to record data available on the basis of tumor size, fixation and invasion of the prostate. Metastasis was evaluated on he basis of radiologic bone survey or bone scan to determine skeletal metastasis and routine chest oentgenograms to eliminate pulmonary lesions. The tumors were staged A through D. Stage A included those cases with either a single nodule in he prostate or occult carcinoma and those cases ound in a surgical specimen in an otherwise unuspected cancer. Stage B was a locally spreading lesion but still considered confined to the anatomic limits of the prostate. Stage C were those cases wherein there was local invasion involving the capule, the periprostatic tissue and the seminal vesicles or both. Stage D cases were those in which at east one distant metastasis was noted. The acid phosphatase level was determined with the commercially available package by the Sigma Chemical Company as used in the laboratory at the hospital. Normal male serum acid phosphatase is 0.13-0.63 Sigma units/ml. This unit is numerically equal to a Bessly-Lowry-Brock unit of phosphatase.

RESULTS

Twenty-five patients were found to have Stage A disease, and one of those (4%) had an elevated acid phosphatase. Six patients were considered to have Stage B disease; of these, two (33%) had elevated acid phosphatase. Thirty-six patients were considered to have Stage C disease; of these 18 (50%) had an elevation of the acid phosphatase. Thirty-three patients had Stage D disease with distant bony metastasis. Of these, 28 patients (86%) had an elevated serum acid phosphatase.

The age distribution of our patients was similar to that seen in other series with approximately 75% of the patients being between the ages of 60 and 80 years.

DISCUSSION

The adult prostate has an acid phosphatase activity 1,000 times greater than that of any other

TABLE 1

PATIENTS WITH INCREASED ACID PHOSPHATASE

Stage	*# of Patients*	*Actual # of Patients of Increased Acid Phosphatase*	*%*
A	25	1	4
B	6	2	33
C	36	18	50
D	33	28	86

tissue, but this activity does not appear until puberty. Also, it has been assumed that as the carcinoma of the prostate grows, more serum acid phosphatase will be produced. Woodard, in 1952, pointed out that acid phosphatase activity of the extra active prostatic carcinoma on the average was considerably less than that found in the normal prostatic tissue. She postulated that there is a barrier between the normal prostate and the serum. As the carcinoma grows this barrier is broken and even though the gland enzyme level is lower than normal, the increased release is enough to raise the serum level to a higher value.

In our Stage B disease patients, 33% had an elevated acid phosphatase, 50% in Stage C and 86% in Stage D. These figures correspond closely to a study by Murphy *et al.* They reported a 36.2% elevation in their Stage B cases, 56.5% in Stage C and 87.6% in Stage D lesions.

The purpose of this study was to call to the attention of practicing physicians again that the finding of a normal serum acid phosphatase does not exclude the possibility of a carcinoma of the prostate. Too often clinicians are lulled into a false feeling of security by the laboratory finding of a normal serum acid phosphatase and, hence, do not consider the possibility of prostatic cancer. Indeed, the percentage incidence of elevated serum acid phosphatase seems related to the increased stage of the disease process.

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(Continued from page 285)

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Portal Hypertension in a Child Due to Extrahepatic Block

Case Report

PORTAL HYPERTENSION is a relatively rare disease in childhood. The causes include portal vein thrombosis,[1, 2] cirrhosis of various causes,[3] congenital hepatic fibrosis,[4–6] congenital portal vein anoma- ies[7, 8] and other miscellaneous factors,[9–12] detailed n the reference.

The case to be presented resulted from probable congenital malformation of the portal venous sys- em with secondary portal and superior mesenteric vein thrombosis. The relative rarity of the condi- ion and the absence of other usual physical find- ngs, except upper gastrointestinal bleeding, de- ayed the diagnosis for 12 years.

The purpose of this report is to document (a) he untreated natural course of the disease over a 2-year period, (b) the relationship of upper respiratory tract infection and onset of upper gastro- ntestinal (GI) bleeding, (c) the delayed demon- tration of esophageal varices with routine barium wallow in children, (d) the absence of clinical plenomegaly as a major deviation from the usual hysical findings and (3) the complete lack of ymptoms between bleeding episodes and remark- ble tolerance of the bleeding bouts.

CASE REPORT

A 2½-year-old white girl was first admitted in uly, 1961 because of the history of rectal bleeding or the previous four months. Her history dated back December, 1960 when she developed upper res- iratory tract infection, which was followed by a arge amount of bloody vomitus. She was hospital- zed at another hospital and was worked up for lood dyscrasias. All tests including upper GI series ere negative, and the patient was discharged in ood condition.

During this first admission, the rectal bleeding lso followed mild upper respiratory tract infection nd conjunctivitis. On physical examination, the hild was well developed but looked moderately pale. o other abnormal physical findings were noted.

Laboratory data were as follows: hematocrit read- ng, 27%; white blood cell count, 32,000/cu mm ith 50% lymphocytes, 36% poly, 14% metamyelo- yte; mild hypochromia, anisocytosis and poikilocy- sis; reticulocyte count, 1.7%; and platelet count, 122,000/cu mm. Other laboratory tests showed no evidence of liver function abnormality or coagulopathy. Bone marrow examination revealed erythroid hyperplasia with adequate megakaryocytes and normal platelet production. Febrile agglutinins were negative. The upper GI series was interpreted as "some duodenal bulb deformity." The child did well during her hospitalization while on bedrest and a bland diet. She was discharged after five days with a diagnosis of possible duodenal ulcer.

The patient was followed as having a possible case of duodenal ulcer. She enjoyed good health and developed normally without any evidence of melena or occult blood loss. On March 30, 1966, she was admitted because of hematemesis. This episode followed an attack of chicken pox. Physical examination again revealed no abnormality. Admission laboratory data were as follows: hemoglobin level, 10.5 gm/100 ml; hematocrit reading 33%; white blood cell count, 3,400/cu mm with 56% polys, 40% lymphocytes, 2% monocytes and 2% eosinophils; and platelet count, 300,000/cu mm. Upper GI series during the same admission was again normal. The patient was again treated for a possible case of duodenal ulcer. Because of precipitous fall in hemoglobin during the first 24 hours, she received a unit of blood. All symptoms improved within 48 hours. She was discharged on a regimen for ulcer after seven days of hospitalization and was discharged to be followed in the outpatient clinic.

On July 20, 1969, the patient was readmitted for recurrence of hematemesis. This again followed a bout of sore throat and fever. Physical examination

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Portal hypertension in childhood is a diagnostic enigma. The importance of this case stems from the well-documented and continuous follow-up of the child for 12 years. The relationship of upper respiratory tract infection with onset of upper gastrointestinal bleeding, inadequacy of barium swallow for demonstration of esophageal varices in children and the complete lack of symptoms except during bleeding episodes are emphasized. Dr. Yesus is a Fellow in Pathology and Dr. Husain is Assistant Professor, Department of Pathology, University of Missouri School of Medicine.

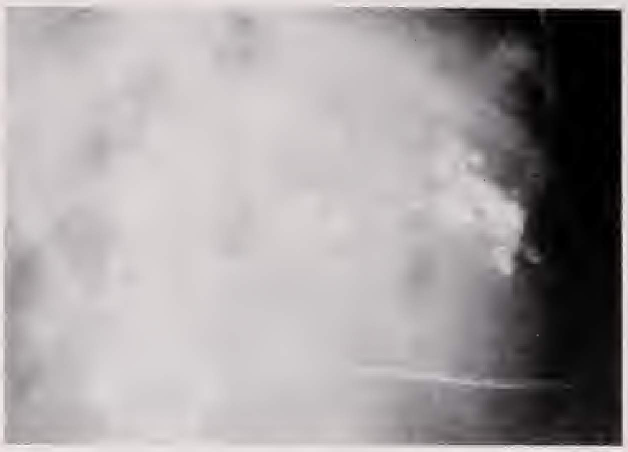

Fig. 1 Splenoportogram. The portal vein is not visualized. Esophageal and gastric varices are evident. The splenic vein is seen and measures 8 mm. (× ⅔)

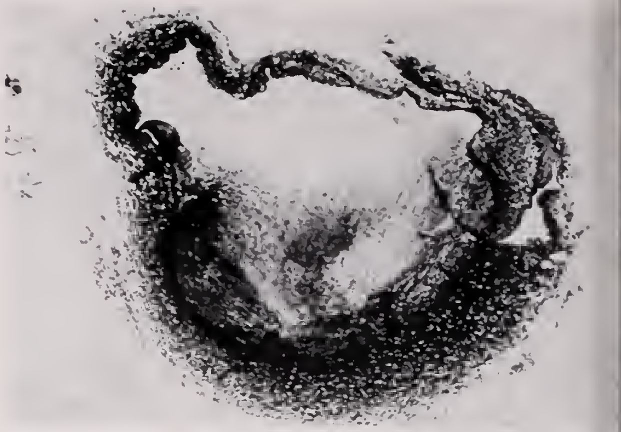

Fig. 2 Section through the superior mesenteric vein shows organized thrombus compromising the lumen. There was no visualization of superior mesenteric vein on splenoportogram. Elastic tissue stain. (×30)

was essentially negative except for slight pallor. Laboratory examination revealed these values: Hgb, 11.2 gm%, Hct 34%, white blood cell count, 6,600/cu mm with 71% polys, 23% lymphocytes, 2% monocytes and 4% eosinophils. Platelet count was 217,000/cu mm, and prothrombin time and partial thromboplastic time were within normal limits. A repeated upper GI series was normal. Barium swallow was negative on two separate occasions during this same admission. The patient again improved on bedrest and on a regimen for ulcer and was discharged to be followed in the clinic. She attended regular four monthly visits. All this time, the patient was developing normally.

Her final admission was on Dec. 8, 1972 for sudden vertigo, hematemesis and hematochezia. On examination, she was a slender, pale, young girl of 14 years with a blood pressure of 98/50, pulse rate of 100, respiration rate of 16 and temperature of 97 F. The only abnormal physical finding was evidence of hematemesis. At no time during previous or present examinations was the spleen palpably enlarged or radiologically increased in size. Laboratory investigation revealed a hematocrit reading of 34%. Serum electrolytes, blood urea nitrogen, glucose, PT, PTT and urinalysis were all within normal limits. A 12.7% retention of Bromosulphalein® (BSP) after 45 minutes was noted. At no time during the follow-up were other abnormal liver function tests noted. An upper GI series was performed and esophageal varices were demonstrated for the first time. Esophageal varices also were noted on endoscopy. A diagnosis of portal hypertension secondary to either congenital hepatic fibrosis or portal vein thrombosis was considered. A splenoportogram showed normal splenic vein and dye in esophageal and gastric varices. There was no filling in either the portal vein or superior mesenteric vein (Fig. 1).

TABLE 1

Vessel Segment	*Circumference in mm*
Portal vein (proximal)	25
Portal vein (distal)	7
Left branch	3
Right branch	3
Ductus venosus	11
Anomalous channels	2-4
Splenic vein (major)	11
Splenic vein (accessory)	4
S. Mesenteric vein	10

During this diagnostic work-up, the patient continued to bleed, requiring multiple transfusions and the passing of a Sengstaken-Blakemore tube on one occasion. Portal decompression was deemed necessary and meso-caval shunt was contemplated. Operative superior mesenteric venography was performed to select the appropriate shunt system. Ten minutes after the injection of 25% hypaque via a small mesenteric vein, the patient had a precipitous drop in blood pressure with bradycardia. Resuscitative efforts that lasted approximately six hours were of no avail.

The detailed description of the postmortem findings were limited to the portal vein, its tributaries and collateral channels. No significant abnormality was seen in other organ systems.

The proximal portion of the portal vein was dilated and showed many fibrous plaques representing old thrombi. The distal half was markedly narrowed as were the left and right branches. Table 1 shows the actual measurements of the different segments of the portal venous system. From the dilated proximal portion of the portal vein arose four anomalous vessels that communicated with a patent ductus venosus, the latter draining into the inferior vena cava via a branch of hepatic vein. The umbilical vein was normally obliterated. The superior mesenteric vein showed a pencil-shaped, organized thrombus compromising the lumen by approximately 75% (Fig. 2). The splenic vein was duplicated. Both the major and accessory splenic veins were widely patent throughout. Figure 3 is a schematic representation of the findings described.

The liver showed no gross or microscopic abnormality. Terminal esophagus demonstrated large varicose channels in the submucosa. No evidence of bleeding or ulceration was noted. The spleen weighed 200 gm and showed moderately severe acute passive congestion.

DISCUSSION

One of the unusual aspects of this case is the length of time from onset of symptoms to diagnosis. This lag period of 12 years offers an excellent opportunity to study the natural course of this disease. The striking difference of this case from others in the literature and probably one of the reasons for late diagnosis is the absence of a palpably enlarged spleen. Shalden *et al*[1] reported 16 cases, 11 of which presented with splenomegaly and five with splenomegaly and upper GI bleeding. All of Hsia's[13] 21 cases had splenomegaly and in four, it was the only symptom. All 58 cases of Voorhees[14] and 28 cases of Walker[15] had varying degrees of splenomegaly. There is no good explanation for why some patients develop massive splenomegaly and others develop only mild splenomegaly. In our case, the portacaval communication via the patent ductus venosus may have affected partial decompression.

Barium swallow, an established procedure for demonstration of varices in adults, has been shown to be of less value in the diagnosis of esophageal varices in children. Shaldon *et al*[16] had 25% false negative in their series. Hsia *et al*[13] demonstrated esophageal varices by barium swallow in nine of their 19 cases with bleeding varices. The same experience is repeated in this case in which eight separate barium swallows were negative. Varices were demonstrated on the ninth barium swallow, by which time the patient was 14 years old. The delay in diagnosis in other series ranged from three months to 11 years and was mainly due to failure to perform splenic venography. Splenic venography and operative mesenteric venography will localize the extrahepatic obstruction. Precise localization is important in designing the appropriate shunt operation.[3]

The most common cause of extra-hepatic portal block is portal vein thrombosis. The cause of portal vein thrombosis in childhood remains a puzzle in the majority of cases. Omphalitis, umbilical vein catheterization, neonatal septicemia, pylephlebitis and abdominal trauma are some of the well known associated factors.[17–19] No history of any of these factors was elicited in our case. What is more, portal vein thrombosis alone does not fully explain the complex of the patent ductus venosus, stenosis of distal half of portal vein and its main branches and the well formed anomalous channels connecting the proximal portal vein with the ductus. Therefore, the authors feel that this represents a case of congenital malformation that was further complicated by the development of portal and superior mesenteric vein thrombosis secondary to portal hypertension.

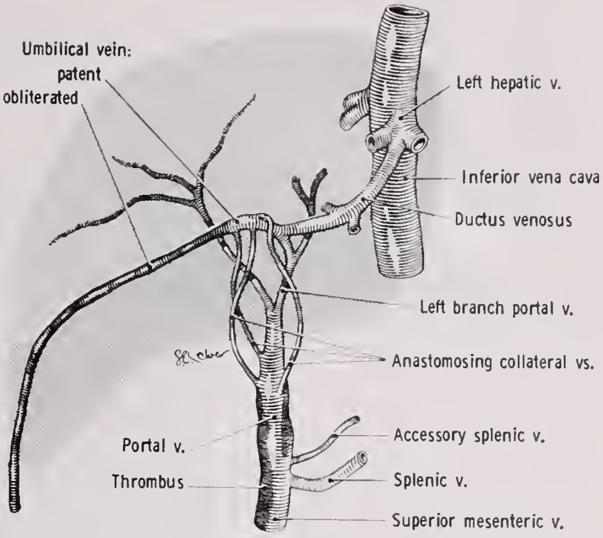

Fig. 3 Schematic illustration of the portal venous system and tributaries.

Other interesting aspects of this condition are that despite the repeated episodes of bleeding these children experience, they develop normally and appear well and healthy in the interval periods. This patient had her first bleeding episode at the age of two and had a total of five bouts until she was 14 years old. She developed normally and led a normal active life except during hospitalization.

The remarkable tolerance of these patients for the bleeding bouts has been observed by many authors.[20, 21] In Voorhees's series, out of the numerous episodes of bleeding among his 56 patients, death due to hemorrhage occurred in only four. Arcari and Lynn[20] noted that by far the great majority of bleeding episodes in patients with extrahepatic portal vein obstruction stopped spontaneously and emergency surgery was not indicated.

The association of febrile upper respiratory tract infection has been noted. Raffensperger *et al*[2] noted that in all their cases with extrahepatic portal hypertension, individual episodes of hemorrhage were almost always precipitated by a febrile illness such as respiratory infection, chicken pox or gastroenteritis. Each of the five bleeding episodes in our patient was preceded by an upper respiratory tract infection. In McEwin's series,[22] however, only six of 29 bleeding episodes followed an overt infection. Specific inquiry concerning the taking of aspirin for febrile episodes that preceded the bleeding bout was not made in any of the published series. The record of our case also contained no such information.

SUMMARY

This was a case of portal hypertension due to extrahepatic block presenting with upper GI bleeding. The probable cause of the block was congenital malformation of the portal venous system with secondary portal and superior mesenteric vein thrombosis. The diagnosis was not established for 12 years despite close follow-up and numerous radiological examinations. The natural history of this disease is well demonstrated.

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> This fixed combination drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual patient. If the fixed combination represents the dosage so determined, its use may be more convenient in patient management. The treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

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Warnings: Do not use dietary potassium supplements or potassium salts unless hypokalemia develops or dietary potassium intake is markedly impaired. Enteric-coated potassium salts may cause small bowel stenosis with or without ulceration. Hyperkalemia (>5.4 mEq/L) has been reported in 4% of patients under 60 years, in 12% of patients over 60 years, and in less than 8% of patients overall. Rarely, cases have been associated with cardiac irregularities. Accordingly, check serum potassium during therapy, particularly in patients with suspected or confirmed renal insufficiency (e.g., elderly or diabetics). If hyperkalemia develops, substitute a thiazide alone. If spironolactone is used concomitantly with 'Dyazide', check serum potassium frequently—both can cause potassium retention and sometimes hyperkalemia. Two deaths have been reported in patients on such combined therapy (in one, recommended dosage was exceeded; in the other, serum electrolytes were not properly monitored). Observe patients on 'Dyazide' regularly for possible blood dyscrasias, liver damage or other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving Dyrenium (triamterene, SK&F). Rarely, leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with the thiazides. Watch for signs of impending coma in acutely ill cirrhotics. Thiazides are reported to cross the placental barrier and appear in breast milk. This may result in fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly other adverse reactions that have occurred in the adult. When used during pregnancy or in women who might bear children, weigh potential benefits against possible hazards to fetus.

Precautions: Do periodic serum electrolyte and BUN determinations. Do periodic hematologic studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in postsympathectomy patients. The following may occur: hyperuricemia and gout, reversible nitrogen retention, decreasing alkali reserve with possible metabolic acidosis, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), digitalis intoxication (in hypokalemia). Use cautiously in surgical patients. Concomitant use with antihypertensive agents may result in an additive hypotensive effect. 'Dyazide' interferes with fluorescent measurement of quinidine.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis; rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting (may indicate electrolyte imbalance), diarrhea, constipation, other gastrointestinal disturbances. Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and, rarely, allergic pneumonitis have occurred with thiazides alone.

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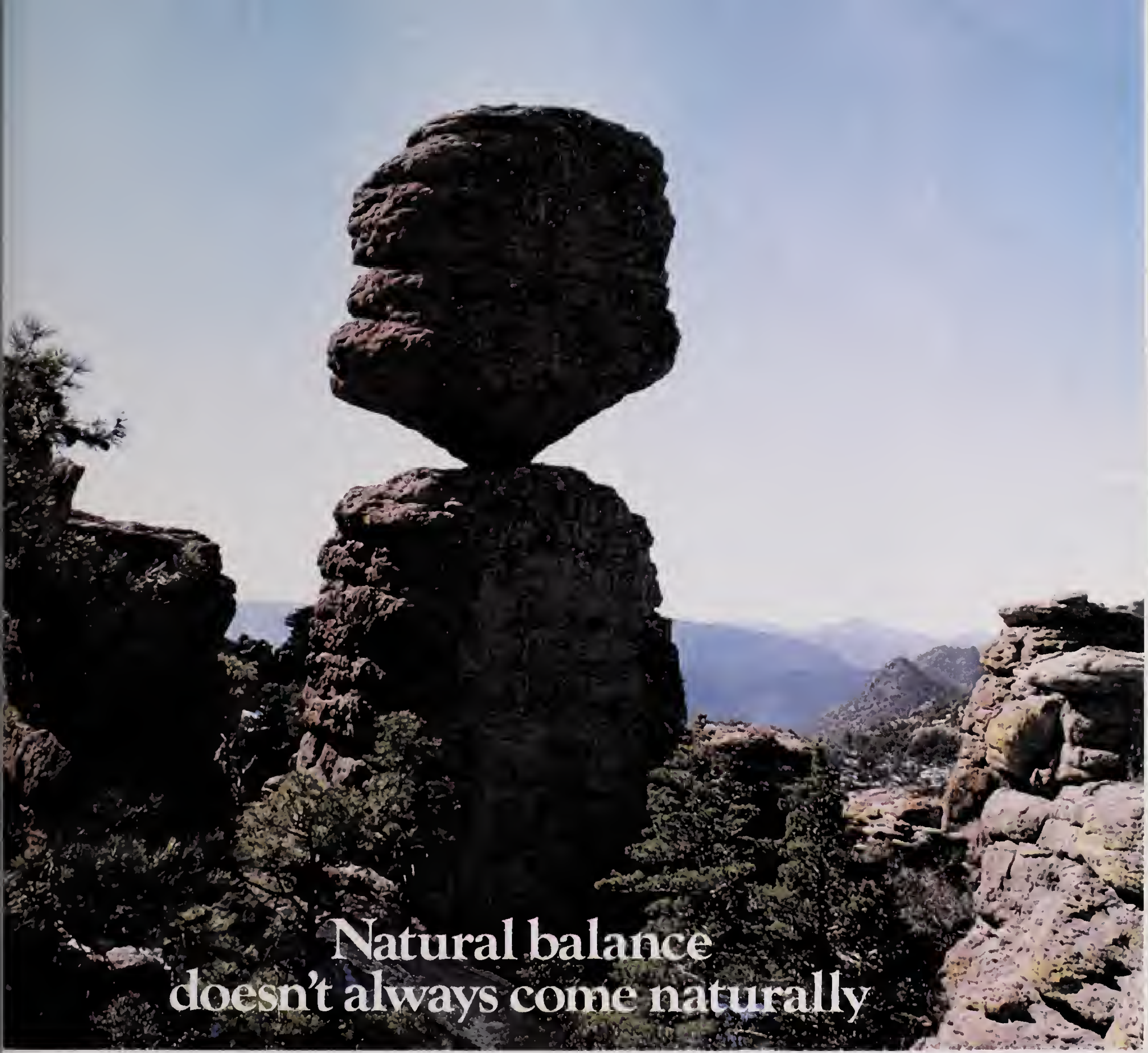

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ossibly Effective: Management of vertigo associated with diseases affecting the tibular system.

inal classification of the less than effective indications requires further estigation.

CONTRAINDICATIONS. Administration of Antivert (meclizine HCl) during pregnancy or to women who may become pregnant is contraindicated in view of the teratogenic effect of the drug in rats.

The administration of meclizine to pregnant rats during the 12-15 day of gestation has produced cleft palate in the offspring. Limited studies using doses of over 100 mg./kg./day in rabbits and 10 mg./kg./day in pigs and monkeys did not show cleft palate. Congeners of meclizine have caused cleft palate in species other than the rat.

Meclizine HCl is contraindicated in individuals who have shown a previous hypersensitivity to it.

WARNINGS. Since drowsiness may, on occasion, occur with use of this drug, patients should be warned of this possibility and cautioned against driving a car or operating dangerous machinery.

Usage in Children: Clinical studies establishing safety and effectiveness in children have not been done; therefore, usage is not recommended in the pediatric age group.

Usage in Pregnancy: See "Contraindications."

ADVERSE REACTIONS. Drowsiness, dry mouth and, on rare occasions, blurred vision have been reported.

More detailed professional information available on request.

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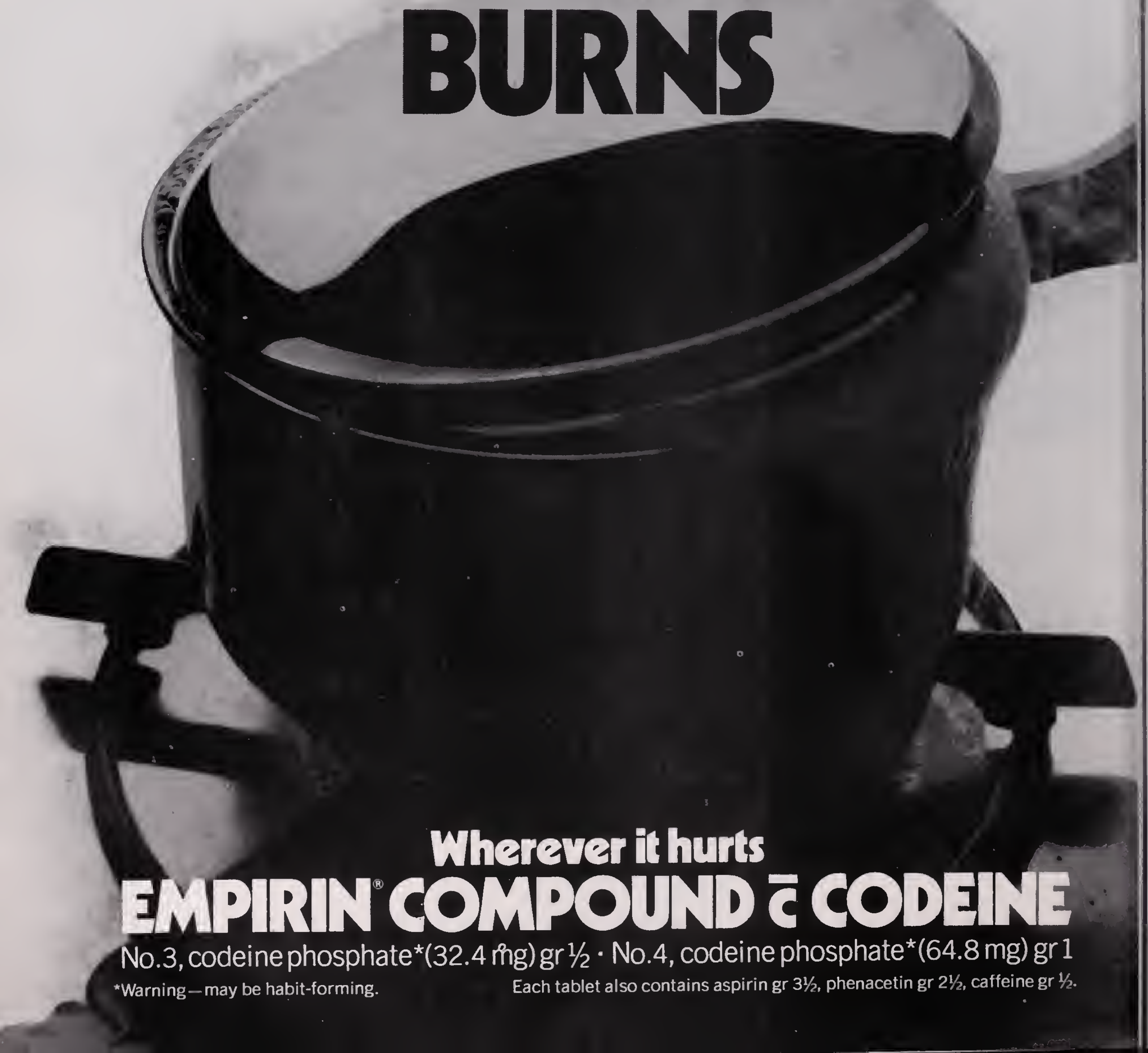

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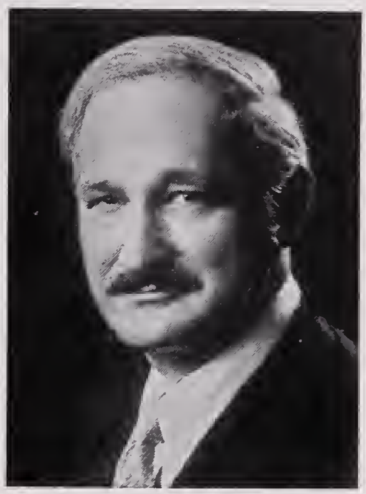
President's Message

Observation of Today's Changing Practice of Medicine

I have had many letters from physicians throughout Missouri and many more conversations about today's practice of medicine as compared to yesteryear's. Also, there has been some conjecturing about what tomorrow holds for the medical practitioner.

Those M.D.s in their 60's and 70's have a wealth of fond memories of the difficult and amusing cases and how they were affected by them and about the fun of practicing medicine, although it meant working 14 and 18 hours a day. With the absolute wonderment of the new era of treatment with the advent of antibiotics, the steroids, the new laboratory and x-ray diagnostic refinements and the new surgical and anesthesia innovations, these men could see the old methods supplanted by the new and were overjoyed at the progress being made. They could really appreciate the new innovations.



R. Allen Chandler, M.D.

The physicians in the middle years had better basic medical school training, but they took for granted the revolutionary methods employed in today's practice of medicine. They had no prior experience with the handful of drugs and the crude surgical methods known by the previous generation. They stated to me, however, that the practice of medicine was a challenge and was fun. They had a free choice geographically and could join a group or practice singly. The practice could be more planned, and some recreational and family time could be set aside. They were more hospital-oriented and made use of these facilities.

Both of the above groups are greatly concerned with the direction medical care is taking. They have seen the insurgence of the third party carriers; Medicare, Medicaid, Champus, and Vocational Rehabilitation. They have seen the compensation commissions and the medical/legal reporting. The minimal free time they used to have is being gobbled up with afterhours of paper work. In some cases, one fourth of their time is so spent. This is regarded as a nonproductive type of work, which physicians abhor.

I have seen more and more physicians from the above mentioned groups go into the VA, the Armed Forces, Public Health, insurance companies and administrative-type situations just to leave the incursion of third party medicine and government interference. Who can blame them? They make about the same money, have more security and work only eight hours a day.

The new M.D.s are really in a bind with the problems previously mentioned already in effect. They may opt for large groups and hospital-oriented practices. Most are incorporating and seeking legal and tax advice regularly. They are anxious about the medical malpractice situation, PSRO, HMOs and the increasing number of office personnel required to handle all types of forms.

They do not appear to be having as much fun in the practice of medicine, however.

If I were in their shoes, I would not be overjoyed with the prospects of national health insurance or socialized medicine in any form. The young are resourceful and resilient, and they will survive. One has only to look at Canada, England and the Scandinavian countries to see what is happening because of socialized medicine. You are familiar with those problems. I can only suggest that if physicians become government employees, they will want the same treatment, such as an eight hour day, and the waiting patients can come back and wait the next day. Talk about shortage of doctors!!! The relative shortage will be staggering.

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Woman's Auxiliary

Is She Sure She's Wanted and Needed?

"For a time, I was a den mother, but it wasn't my idea. I was asked. I also did my stint with the PTA. But, again, I didn't volunteer. I was made to feel that my help was needed. I worked for the Girl Scouts, Meals-on-Wheels and the hospital auxiliary, and I served on my Sister City Commission. There were others. Always, I was invited.

"I wouldn't have volunteered for any of them and not because of opposition to helping. Not at all. I think that, subconsciously, I felt that it is pushy to volunteer and, apparently, many people feel that way. It is an unusual person who spontaneously seeks a job. Even in the medical auxiliary—our own special organization—there is hesitation. We need encouragement. We need an invitation."

So reasoned the President of the AMA Auxiliary. It is true. We do need an invitation.

There are many kinds of invitations, and the Auxiliary has tried many of them. They vary from the impersonal, mimeographed meeting notices, which usually are enclosed with a dues listing, to a personal, friendly phone call and offer to drive by and take the prospective member to a meeting.

Mrs. William R. McPhee
President

The most persuasive invitation by far is the one made by a physician who asks his wife to join the Auxiliary and to make her membership one that counts. When *he* asks *her* to join *him* and his Association in participating in providing health-related community services, in helping students who are trying to manage medical educations, in becoming informed and in really being in the business of helping people—*well, how can she refuse?*

If a physician's wife knows she is welcomed by fellow members and, in addition, that her husband approves and encourages such action, she'll truly know that she is wanted and needed.

An Auxiliary membership means more than "just joining." It means belonging. It means having fun together, becoming knowledgeable about medicine's problems, filling community needs and becoming involved in worthwhile projects.

Most important, it means sharing it all with our physician-husbands.

County Society News

FIRST DISTRICT

COUNCILOR
JOHN N. MARTIN, M.D., ST. JOSEPH

Buchanan County Medical Society

For the 23rd consecutive year, members of the Buchanan County Medical Society and the Northwest Missouri Dental Society held a joint meeting and program.

A dinner and scientific session were held at the Circle-W Restaurant in St. Joseph on May 7. Presidents of the two organizations presided jointly. They are William B. O'Connor, M.D. and Cecil R. Albright, D.D.S.

Speaker for the event was Bernard Butterworth, Ph.D., Professor of Anatomy and Director of Graduate Studies at the University of Missouri-Kansas City School of Dentistry. He spoke on "Propagation of Infections in the Face."

James Turner, Director for Education at the Dental School, assisted Dr. Butterworth in the presentation.

Arrangements for the meeting were made by the program chairmen of the two societies, A. L. Ingino, D.D.S. and Edward H. Andres, M.D. Dr. Ingino introduced the participants.

Carl K. Ness, M.D., *Secretary*

SIXTH DISTRICT

COUNCILOR
WILLIAM D. BRADSHAW, M.D., CLINTON

West Central Missouri Medical Society

Dr. John Torontow *(extreme left)* presents the MSMA 50-year pin to Dr. Forrest L. Martin *(seated)* in a special ceremony. Others present *(from left)* are Dr. William Allen, Mrs. Martin, Dr. R. B. Wray, Dr. Roy Pearse and Dr. C. Braxton Davis.

Dr. Forrest L. Martin of Nevada, who was unable to attend the 117th Annual Session of the Missouri State Medical Association in St. Louis, received his MSMA 50-Year pin from Dr. John Torontow in a special ceremony in Nevada on April 25. The pin which recognizes Dr. Martin as a physician for 50 years, was to have been presented at the Annual Session.

Dr. Martin's membership in the MSMA began when he joined the original Vernon-Cedar County Medical Society, which was organized in 1925. Mrs. Martin and four other members of West Central Missouri Medical Society, who also were members of the original Society, attended the ceremony. They are Dr. William Allen, Dr. R. B. Wray, Dr. Roy Pearse and Dr. C. Braxton Davis, all of Nevada.

Dr. Paul Barone of Nevada, who also was a member of the Vernon-Cedar County Society, was unable to attend the ceremony.

EIGHTH DISTRICT

COUNCILOR
HOWARD J. McALHANY, M.D., SPRINGFIELD

Jasper County Medical Society

Members of the Jasper County Medical Society and the Jasper County Bar Association and their wives held a joint dinner meeting on May 13 at Twin Hills Golf and Country Club in Joplin.

The program was presented by James W. Jeans, Professor of Law at the University of Missouri-Kansas City. His subject was "Medical Testimony, Its Purpose, Method of Presentation and Related Matters."

Professor Jeans is a native of St. Louis and received his A.B. and J.D. degrees from Washington University. He is a frequent lecturer at medical-legal seminars and contributor to various legal publications. He is a member of the faculty of the National Institute of Trial Advocacy, the International Academy of Trial Lawyers and the American Trial Lawyers Association.

Ozarks Medical Society

The Ozarks Medical Society met at Hills Restaurant in Neosho in April.

There was considerable discussion concerning compulsory membership in the AMA. It was the unanimous conclusion of the Society members present that this is inadvisable.

There being no further business, the meeting was adjourned.

A. J. Graves, M.D., *Secretary*

New Members

Emmanuel A. Afuwape, M.D., 2601 N. Whit- ier, St. Louis, has become a member of St. Louis edical Society. Dr. Afuwape is a native of Ni- eria, received his preliminary education at Kings ollege and his M.D. degree at the University of badan in 1968. He specializes in general surgery.

Stephen C. Allen, M.D., St. John's Hospital, pringfield, has become a member of Greene ounty Medical Society. Dr. Allen is a native of offeyville, Kan., received his preliminary educa- on at the University of Oklahoma and his M.D. egree at the University of Oklahoma in 1966. He ecializes in emergency medicine.

John H. Askew, M.D., 1012 N. Main, Sikeston, as become a member of SEMO County Medical ociety. Dr. Askew is a native of Tampa, Fla., re- eived his preliminary education at Mississippi Col- ge and his M.D. degree at the University of Ten- essee in 1971. He is in general medicine.

William V. Booth, M.D., One Mile Road, Dex- r, has become a member of SEMO County Med- al Society. Dr. Booth is a native of Auburndale, la., received his preliminary education at the Uni- ersity of Southwestern Louisiana and his M.D. de- ree at Louisiana State University in 1966. He spe- alizes in general surgery.

Donald H. Brancato, M.D., 1245 Graham Rd., lorissant, has become a member of St. Louis edical Society. Dr. Brancato is a native of Wash- gton, D. C., received his preliminary education Northwestern University and his M.D. degree at orthwestern University in 1967. He specializes in thopedic surgery.

Leonard L. Brubaker, M.D., 807 Stadium, Co- mbia, has become a member of Boone County edical Society. Dr. Brubaker is a native of Ma- on, Ga., received his preliminary education at uke University and his M.D. degree at Emory niversity in 1964. He specializes in hematology d oncology.

Kenneth E. Callen, M.D., 807 Stadium, Colum- a, has become a member of Boone County Med- al Society. Dr. Callen is a native of Clinton, re- eived his preliminary education at the University Missouri and his M.D. degree at the University Missouri in 1965. He specializes in psychiatry.

David R. Challoner, M.D., 1402 S. Grand, St. Louis, has become a member of St. Louis Medical Society. Dr. Challoner is a native of Wisconsin, received his preliminary education at Lawrence College and his M.D. degree at Harvard University in 1961. He specializes in internal medicine.

Frank I. Clark, III, M.D., 3107 McClelland Blvd., Joplin, has become a member of Jasper County Medical Society. Dr. Clark is a native of Kansas City, received his preliminary education at the University of Colorado and his M.D. degree at the University of Colorado in 1969. He specializes in pediatrics.

Harry B. Cohen, M.D., 807 Stadium, Columbia, has become a member of Boone County Medical Society. Dr. Cohen is a native of Little Rock, Ark., received his preliminary education at the University of Oklahoma and his M.D. degree at Creighton University in 1974. He specializes in anesthesiology.

James W. Coulter, M.D., 1550 E. Sunshine, Springfield, has become a member of Greene County Medical Society. Dr. Coulter is a native of Boston, Mass., received his preliminary education at Loyola University and his M.D. degree at Marquette University in 1968. He specializes in pulmonary diseases.

Herbert W. Craig, M.D., 807 Stadium, Columbia, has become a member of Boone County Medical Society. Dr. Craig is a native of Chillicothe, received his preliminary education at the University of Kansas and his M.D. degree at the University of Kansas in 1966. He specializes in orthopaedic surgery and physical medicine.

Donald Dickhaus, M.D., 807 Stadium, Columbia, has become a member of Boone County Medical Society. Dr. Dickhaus is a native of St. Louis, received his preliminary education at the University of Missouri and his M.D. degree at Tulane University in 1956. He specializes in cardiology and internal medicine.

Lherrisson Domond, M.D., 3733 Lindell Blvd., St. Louis, has become a member of St. Louis Medical Society. Dr. Domond is a native of Haiti, received his preliminary education at Lycee T. Louverture Port-au-Prince and his M.D. degree at the Medical School of Haiti in 1964. He specializes in obstetrics and gynecology.

James A. Esterly, M.D., 807 Stadium, Columbia, has become a member of Boone County Medical

Society. Dr. Esterly is a native of Bismarck, N. D., received his preliminary education at North Central College (Ill.) and his M.D. degree at the University of Chicago in 1963. He specializes in pathology.

Corinne Farrell, M.D., 807 Stadium, Columbia, has become a member of Boone County Medical Society. Dr. Farrell is a native of Ellensburg, Wash., received his preliminary education at Central Washington College and his M.D. degree at Creighton University in 1957. He specializes in radiology.

Frank Fristoe, Jr., M.D., 807 Stadium, Columbia, has become a member of Boone County Medical Society. Dr. Fristoe is a native of Kansas City, received his preliminary education at William Jewell College and his M.D. degree at the University of Missouri in 1966. He specializes in pathology.

Alice F. Gambill, M.D., 807 Stadium, Columbia, has become a member of Boone County Medical Society. Dr. Gambill is a native of Pawhuska, Okla., received her preliminary education at Oklahoma University and her M.D. degree at Oklahoma University in 1949. She specializes in anesthesiology.

Charles Gideon, M.D., 2601 N. Whittier, St. Louis, has become a member of St. Louis Medical Society. Dr. Gideon is a native of India, received his preliminary education at Science College and his M.D. degree at Madras University in 1964. He specializes in obstetrics and gynecology.

Edward Gwin, M.D., 1515 E. Sunshine, Springfield, has become a member of Greene County Medical Society. Dr. Gwin is a native of Ada, Okla., received his preliminary education at East Central State College and his M.D. degree at Oklahoma University in 1966. He specializes in internal medicine.

T. W. Henderson, M.D., One Mile Road, Dexter, has become a member of SEMO County Medical Society. Dr. Henderson is a native of Memphis, Tenn., received his preliminary education at Harding College and his M.D. degree at the University of Tennessee in 1972. He is in family practice.

Alexander T. Herzen, M.D., 1325 S. Grand, St. Louis, has become a member of St. Louis Medical Society. Dr. Herzen is a native of the state of California, received his preliminary education at the University of Southern California and his M.D. degree at St. Louis University in 1970. He specializes in ophthalmology.

Waseem Kamal, M.D., 807 Stadium, Columbia, has become a member of Boone County Medical Society. Dr. Kamal is a native of Pakistan, received his preliminary education at Islamia College and his M.D. degree at King Edward College in 1961. He specializes in ophthalmology.

Fuad H. Kandalaft, D.O., 112 S. Walnut, Dexter, has become a member of SEMO County Medical Society. Dr. Kandalaft is a native of Jerusalem, received his preliminary education at the University of Alabama and his D.O. degree at Kirksville College of Osteopathic Medicine in 1959. He is in family practice.

Jong Ku Kim, M.D., 1755 S. Grand, St. Louis, has become a member of St. Louis Medical Society. Dr. Kim is a native of Korea, received his preliminary education at Korea University and his M.D. degree at Korea University in 1964. He specializes in surgery.

Kobby J. Kobbermann, M.D., 1636 S. Glenstone, Springfield, has become a member of Greene County Medical Society. Dr. Kobbermann is a native of Pittsfield, Ill., received his preliminary education at Drury College and his M.D. degree at Missouri University in 1969. He specializes in obstetrics and gynecology.

Joseph Lamberti, M.D., 807 Stadium, Columbia, has become a member of Boone County Medical Society. Dr. Lamberti is a native of Toronto, Canada and received his M.D. degree at the University of Ottawa in 1954. He specializes in psychiatry.

Tai-Sun Lin, M.D., 2601 N. Whittier, St. Louis, has become a member of St. Louis Medical Society. Dr. Lin is a native of Taiwan, received his preliminary education at Kaohsiung Medical College and his M.D. degree at Kaohsiung Medical College in 1967. He specializes in obstetrics and gynecology.

S. Lopansri, M.D., 3015 N. Ballas Rd., St. Louis, has become a member of St. Louis Medical Society. Dr. Lopansri is a native of Thailand and received his M.D. degree at Chiengmai School of Medicine in 1967. He specializes in internal medicine.

Armando Martinez, M.D., 2601 N. Whittier, St. Louis, has become a member of St. Louis Medical Society. Dr. Martinez is a native of Central America, received his preliminary education at National nstitute and his M.D. degree at the University of l Salvador in 1953. He specializes in surgery.

Lana K. Minnigerode, M.D., 2316 E. Meyer lvd., Kansas City, has become a member of Jack-n County Medical Society. Dr. Minnigerode is a ative of Brookfield, received her preliminary edu-ation at the University of Missouri and her M.D. egree at the University of Missouri in 1966. She pecializes in physical medicine and rehabilitation.

Carl M. Myers, M.D., 6601 Rockhill Rd., Kansas ity, has become a member of Jackson County ledical Society. Dr. Myers is a native of Leaven-orth, Kan., received his preliminary education at ne University of Missouri and his M.D. degree at ne University of Missouri in 1974. He is in family ractice.

Raiz A. Naseer, M.D., 1515 Lafayette, St. Louis, as become a member of St. Louis Medical Socie-. Dr. Naseer is a native of India and received his I.D. degree at Dow Medical College in 1969. He pecializes in pediatrics.

Manuel I. Navarro, M.D., 807 Stadium, Colum-ia, has become a member of Boone County Med-al Society. Dr. Navarro is a native of Nicaragua, eceived his preliminary education at National In-itute of Nicaragua and his M.D. degree at the ational University of Nicaragua in 1957. He spe-alizes in neuro-radiology.

R. F. X. Noronha, M.D., 1325 S. Grand, St. Lou-, has become a member of St. Louis Medical So-ety. Dr. Noronha is a native of Kenya, received is preliminary education at Makerere College and is M.D. degree at the University of Makerere in 963. He specializes in urology.

Ofelia S. Ong, M.D., 2601 N. Whittier, St. Louis, as become a member of St. Louis Medical Society. r. Ong is a native of the Philippines, received er preliminary education at Far Eastern Univer-ty and her M.D. degree at Far Eastern University 1967. She specializes in obstetrics and gynecol-gy.

William J. Ott, M.D., 1310 S. Grand, St. Louis, as become a member of St. Louis Medical Socie-. Dr. Ott is a native of St. Louis, received his reliminary education at the University of Notre ame and his M.D. degree at St. Louis University 1970. He specializes in obstetrics and gynecology.

John F. Patterson, M.D., Rt. 2, Box 53, Marsh-eld, has become a member of Webster County Medical Society. Dr. Patterson is a native of West Plains, received his preliminary education at the University of Missouri and his M.D. degree at the University of Missouri in 1965. He is in family practice.

Charles R. Peterson, M.D., 301 McHaney, 807 Stadium, Columbia, has become a member of Boone County Medical Society. Dr. Peterson is a native of Rockford, Ill., received his preliminary education at Northwest University and his M.D. degree at George Washington University in 1955. He specializes in physical medicine and rehabilitation.

Paul J. Petruska, M.D., 1325 S. Grand, St. Louis, has become a member of St. Louis Medical Society. Dr. Petruska is a native of Massachusetts, received his preliminary education at St. Peter's College and his M.D. degree at St. Louis University in 1967. He specializes in internal medicine, hematology and oncology.

Leucha Rutngamlug, M.D., 1225 Graham Rd., Florissant, has become a member of St. Louis Medical Society. Dr. Rutngamlug is a native of Thailand, received his preliminary education at Chulalongkorn University and his M.D. degree at Chulalongkorn University in 1968. He specializes in general surgery.

Malladi R. Sastry, M.D., 1515 Lafayette, St. Louis, has become a member of St. Louis Medical Society. Dr. Sastry is a native of India and received his M.D. degree at Armed Forces Medical College in 1966. He specializes in internal medicine.

Eleanor Shaheen, M.D., 807 Stadium, Columbia, has become a member of Boone County Medical Society. Dr. Shaheen is a native of Altoona, Pa., received her preliminary education at Pennsylvania State University and her M.D. degree at the University of Pennsylvania in 1950. She specializes in pediatrics.

Ali R. Shreim, M.D., 1012 N. Main, Sikeston, has become a member of SEMO County Medical Society. Dr. Shreim is a native of Lebanon and received his M.D. degree at Tabriz Medical School in 1969. He specializes in internal medicine and hematology.

John F. Simonds, M.D., 807 Stadium, Columbia, has become a member of Boone County Medical Society. Dr. Simonds is a native of New York, received his preliminary education at Georgetown University and his M.D. degree at Georgetown University in 1959. He specializes in child psychiatry.

In Memoriam

Robert H. Young, M.D., Moberly, a graduate of Washington University, 1940; member of Chariton-Macon-Monroe-Randolph County Medical Society; age 61; died April 7, 1975.

William F. Culbertson, M.D., 1253 Huntington Rd., Kansas City, a graduate of the University Medical College, 1910; member of Jackson County Medical Society; age 87; died April 11, 1975.

Eugene T. Taylor, M.D., 2602 N. Union Blvd., St. Louis, a graduate of Meharry Medical College, 1915; member of St. Louis Medical Society; age 92; died April 11, 1975.

Robert H. Parker, M.D., 5601 N. Antioch Rd., Kansas City, a graduate of Rush Medical College, 1937; member Clay County Medical Society; age 64; died April 13, 1975.

Carl E. Rice, M.D., 1050 Nancy Carol La., Glendale, a graduate of Washington University, 1920; member Jefferson County Medical Society; age 83; died April 15, 1975.

Milton C. Peterson, M.D., 10519 Tropicana Circle, Sun City, Ariz., a graduate of the University of Wisconsin, 1933; member of Jackson County Medical Society; age 68; died Jan. 1, 1975.

Charles B. Keeble, M.D., 37 Villawood La., St. Louis, a graduate of Washington University, 1922; member of St. Louis Medical Society; age 78; died April 26, 1975.

Chester R. Peck, Jr., M.D., Kennett, a graduate of Washington University, 1942; member Dunklin County Medical Society; age 59, died April 30, 1975.

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PRESCRIBING INFORMATION
Antiminth (pyrantel pamoate) Oral Suspension

Actions. Antiminth (pyrantel pamoate) has demonstrated anthelmintic activity against *Enterobius vermicularis* (pinworm) and *Ascaris lumbricoides* (roundworm). The anthelmintic action is probably due to the neuromuscular blocking property of the drug.

Antiminth is partially absorbed after an oral dose. Plasma levels of unchanged drug are low. Peak levels (0.05-0.13μg/ml.) are reached in 1-3 hours. Quantities greater than 50% of administered drug are excreted in feces as the unchanged form, whereas only 7% or less of the dose is found in urine as the unchanged form of the drug and its metabolites.

Indications. For the treatment of ascariasis (roundworm infection) and enterobiasis (pinworm infection).

Warnings. *Usage in Pregnancy:* Reproduction studies have been performed in animals and there was no evidence of propensity for harm to the fetus. The relevance to the human is not known.

There is no experience in pregnant women who have received this drug.

Precautions. Minor transient elevations of SGOT have occurred in a small percentage of patients. Therefore, this drug should be used with caution in patients with pre-existing liver dysfunction.

Adverse Reactions. The most frequently encountered adverse reactions are related to the gastrointestinal system.

Gastrointestinal and hepatic reactions: anorexia, nausea, vomiting, gastralgia, abdominal cramps, diarrhea and tenesmus, transient elevation of SGOT.

CNS reactions: headache, dizziness, drowsiness, and insomnia. Skin reactions: rashes.

Dosage and Administration. *Children and Adults:* Antiminth Oral Suspension (50 mg. of pyrantel base/ml.) should be administered in a single dose of 11 mg. of pyrantel base per kg. of body weight (or 5 mg./lb.); maximum total dose 1 gram. This corresponds to a simplified dosage regimen of 1 cc. of Antiminth per 10 lb. of body weight. (One teaspoonful = 5 cc.)

Antiminth (pyrantel pamoate) Oral Suspension may be administered without regard to ingestion of food or time of day, and purging is not necessary prior to, during, or after therapy. It may be taken with milk or fruit juices.

How Supplied. Antiminth is available as a pleasant tasting caramel-flavored suspension which contains the equivalent of 50 mg. pyrantel base per ml., supplied in 60 cc. bottles and Unitcups™ of 5 cc. in packages of 12.

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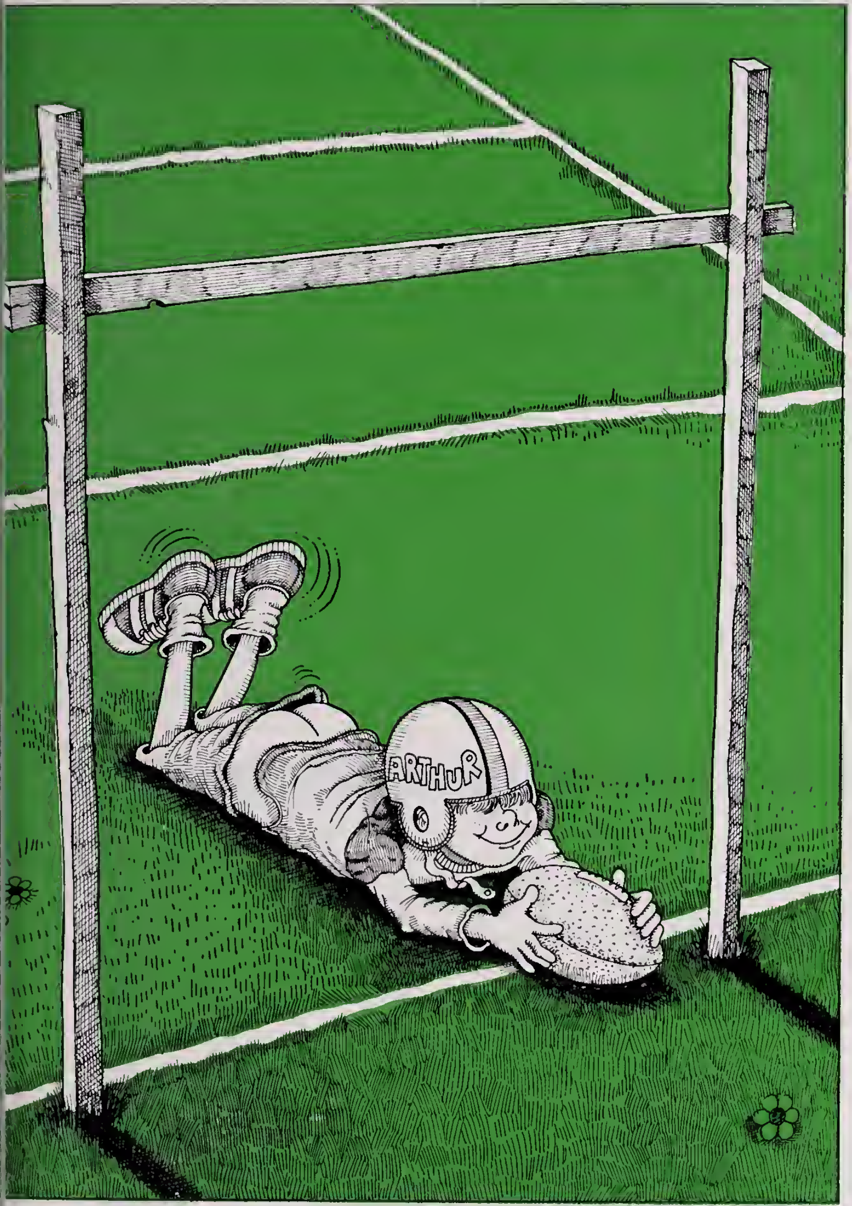
WORMS BLITZED



A single dose of Antiminth (1 cc. per 10 lbs. of body weight, 1 tsp./50 lbs. —maximum dose, 4 tsp.=20 cc.) offers highly effective control of *both* pinworms and roundworms.

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LEO H. POLLOCK, M.D

Missouri Medicine in Review

FORTY YEARS AGO

The Public Welfare Committee of the Board of Aldermen of St. Louis is to be commended on disapproving a bill which would have made it impossible for the medical schools to obtain dogs from the city pound for experimental purposes. The Board met with much opposition since there was widespread agitation for its passage, although the *St. Louis Post-Dispatch* consistently opposed the bill which would "hold St. Louis up to ridicule in the scientific world."

A bill introduced by Sen. Allen McReynolds of Carthage and passed by the Missouri Legislature increases the number of physicians on the medical staffs of the state eleemosynary institutions. Ten will be assigned to the state hospitals—four at St. Joseph, three at Fulton, two at Nevada and one at Farmington. Two will go to the staff of the State School for the Feeble Minded at Marshall and two new physicians at the Mt. Vernon Sanatorium will give that institution five assistant physicians.

The bill was sponsored in the House by Rep. H. P. Lauf of Cole County. "Economy" arguments were raised against it by Rep. John D. Taylor of Chariton County. For a sum estimated to be $25,000 to $30,000 a year by Senator McReynolds, the state, through this bill, goes a long way toward remedying an outstanding fault in the care it has given to its unfortunates in the past. The medical staffs have been lamentably inadequate. With one physician for each 600 patients, it has been physically impossible to give each patient the type of care that would most promptly return him to his family and to a responsible position in society.

TWENTY-FIVE YEARS AGO

Intern and residency programs in hospitals approved by the AMA Council on Medical Educatio and Hospitals have increased during the past te years. The Council's annual report in the April 1 issue of *The Journal of the American Medical Association,* shows there were 9,398 approved internships available as of April 1. This compares wit 9,124 of a year ago and 7,998 in the prewar year o 1940.

Approved residencies offered to physicians fo further training in the specialties totalled 18,69 as of April 1 as compared to 15,172 of two year ago.

The increase of 814 internships over the las four years involves virtually the same number o approved hospitals, 799 and 798 respectively fo 1950 and 1946. This trend toward a greater demand for intern service is a significant factor i considering the present shortage of interns, th Council states.

TEN YEARS AGO

Dr. M. Kenton King has been named dean o Washington University School of Medicine in St Louis. Dr. King was named acting dean of th school in September when Dr. Edward Dempse who had been dean for six years, resigned to tak a leave of absence as professor of anatomy to become special assistant to Secretary of Health, Education and Welfare Anthony Celebrezze. Dr. Kin has served as associate dean since 1962. He joine the faculty of Washington University in 1957 an served as director of the Student Health Servic from 1957 to 1962. He now holds the titles of associate professor of preventive medicine and medicine.

Dr. John C. Herweg, associate professor of pediatrics at Washington University, has been name associate dean of the School of Medicine with responsibility for student affairs. He received hi M.D. degree from Washington University and hi B.S. degree from Drury College.

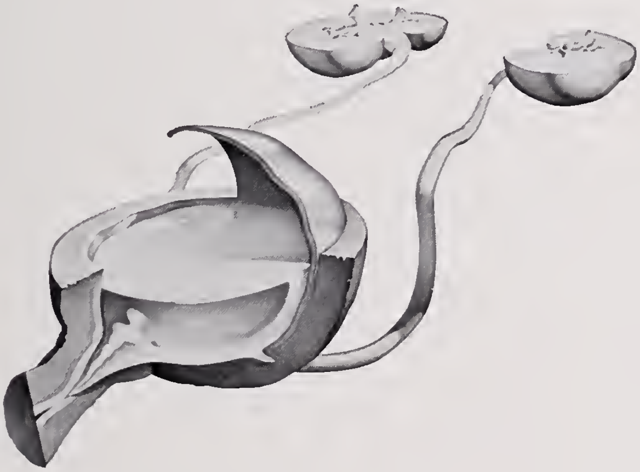
A portrait of Dr. G. O. Broun, Sr., dean emeritus, St. Louis University School of Medicine, wa unveiled and presented to St. Louis University b Dr. R. Emmet Kelly, president of the Medica Alumni Association, at a ceremony on March 19 A gift of the Alumni Association, the portrait wa painted by Mrs. Dorothy Quest, a St. Louis artist.

In patients with chronic or frequently recurrent urinary tract infections

Bactrim™ outperforms ampicillin.

In new multicenter studies a higher percentage of Bactrim-treated patients maintained clear cultures for four, six and eight weeks.

See charts on following page for details of studies.



For chronic cystitis or pyelonephritis evidenced by persistent bacteriuria, requently recurrent infections or infections associated with urinary tract complications, when infection is due to susceptible organisms.

Bactrim™

(80 mg trimethoprim/400 mg sulfamethoxazole)

Before prescribing, please consult complete product information, a summary of which follows:
INDICATIONS: Chronic urinary tract infections evidenced by persistent bacteriuria (symptomatic or asymptomatic), frequently recurrent infections (relapse or reinfection), or infections associated with urinary tract complications, such as obstruction. Primarily for cystitis, pyelonephritis or pyelitis due to susceptible strains of *E. coli, Klebsiella-Enterobacter, Proteus mirabilis, Proteus vulgaris* and *Proteus morganii.*

Note: The increasing frequency of resistant organisms limits the usefulness of antibacterials, especially in these urinary tract infections.
The recommended quantitative disc susceptibility method (*Federal Register 37*:20527-20529, 1972) may be used to estimate bacterial susceptibility to Bactrim. A laboratory report of "Susceptible to trimethoprim-sulfamethoxazole" indicates an infection likely to respond to Bactrim therapy, "Intermediate susceptibility" also indicates a likely response and "Resistant" that response is unlikely.

Contraindications: Hypersensitivity to trimethoprim or sulfonamides; pregnancy; nursing mothers.

Warnings: Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted. Data are insufficient to recommend use in infants and children under 12.

Precautions: Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function.

Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. *Blood dyscrasias:* Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. *Allergic reactions:* Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. *Gastrointestinal reactions:* Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis. *CNS reactions:* Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. *Miscellaneous reactions:* Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L.E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.

DOSAGE: Not recommended for children under 12.
Usual adult dosage: 2 tablets b.i.d. for 10 to 14 days.
For patients with renal impairment:

Creatinine Clearance (ml/min)	Recommended Dosage Regimen
Above 30	Usual standard regimen
15-30	2 tablets every 24 hours
Below 15	Use not recommended

Supplied: Tablets, each containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 40, available singly and in trays of 10.

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In new multicenter studies of patients with chronic or frequent recurrent urinary tract infections

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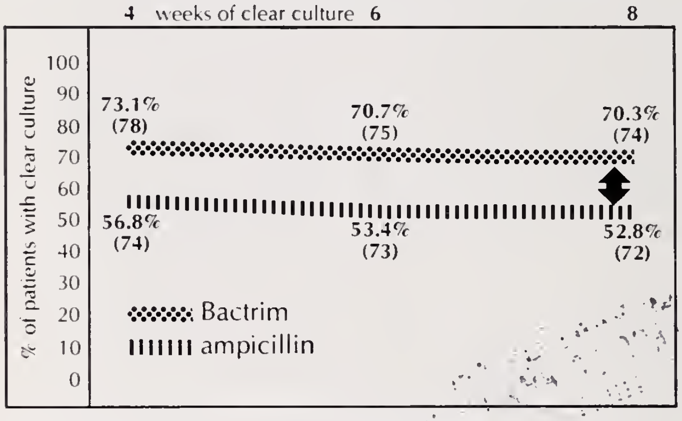
(80 mg trimethoprim/400 mg sulfamethoxazole)

outperforms ampicilli

Bactrim vs ampicillin. 10-day therapy. 157 patients.



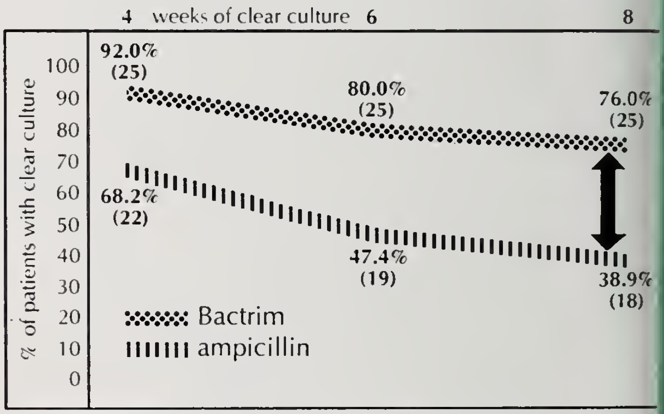
Criterion for clear culture: 1000 or fewer organisms/ml of urine.
Numbers in parentheses: No. of patients evaluated for this time period.

17.5% The Bactrim plus.

Patients maintaining clear cultures for 8 weeks

Bactrim: 70.3%
ampicillin: 52.8%

Bactrim vs ampicillin. 28-day therapy.* 53 patients.



Criterion for clear culture: 1000 or fewer organisms/ml of urine.
Numbers in parentheses: No. of patients evaluated for this time period.

37.1% The Bactrim plus.

Patients maintaining clear cultures for 8 weeks

Bactrim: 76.0%
ampicillin: 38.9%

In two multiclinic, double-blind studies of patients with chronic or frequently recurrent urinary tract infections, Bactrim maintained a higher rate of clear cultures than ampicillin. All patients had "significant bacteriuria" (100,000 or more organisms/ml of urine) on two consecutive pretreatment cultures; many had previously undergone multiple treatment programs and/or surgery. Organisms were *E. coli* and *Proteus mirabilis*.

Side effects were relatively mild (e.g., nausea, vomiting, rash), but more serious side effects can occur with the agents studied. Please consult the manufacturers' product information for all warnings, precautions, contraindications and adverse reactions.

*While the usual therapy regimen for Bactrim is 10 to 14 days, patients with chronic urinary tract infections can be and are treated for substantially longer periods with standard agents such as ampicillin. These studies, therefore, include both 10-day and 28-day courses of therapy. In both studies dosage was one 500-mg ampicillin capsule q.i.d. or two Bactrim tablets b.i.d. plus placebos to make each drug regimen appear identical.

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Please see preceding page for summary of product information.

Missouri Medicine

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VOLUME 72, NUMBER 7

Special Report:

ACTIONS and EVENTS
of the
Missouri State Medical Association

117th
ANNUAL SESSION

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118th MSMA Annual Session
April 1-4, 1976, Kansas City

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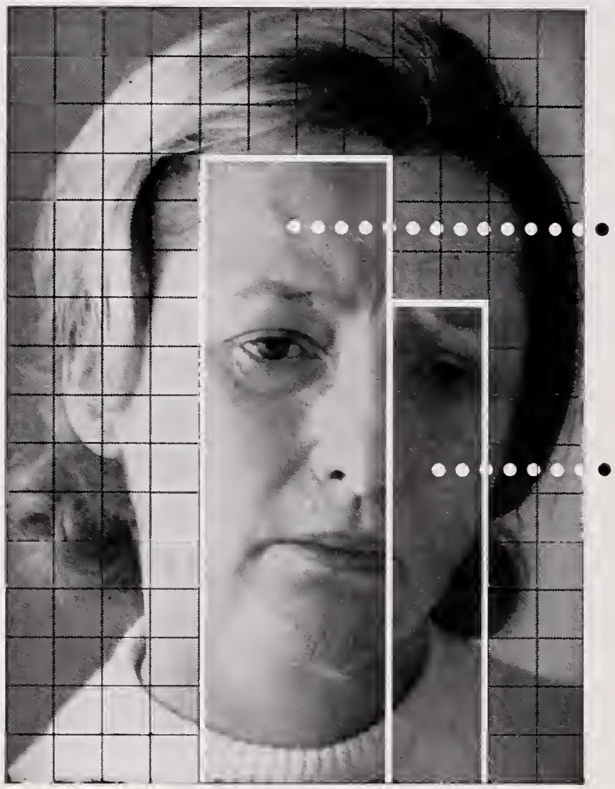

Predominant psychoneurotic anxiety

Associated depressive symptoms

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in fr
and/or severity of grand mal seizu
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therapeutic effect of
n is pronounced and
This means that im-
nent is usually apparent in the patient within a few days rather than in a week or two, although it may take longer in some patients. In addition, Valium (diazepam) is generally well tolerated; as with most CNS-acting agents, caution patients against hazardous occupations requiring complete mental alertness.

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Valium®
(diazepam)
2-mg, 5-mg, 10-mg tablets

in psychoneurotic
anxiety states
with associated
depressive symptoms

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abituation and dependence. In
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age, weigh potential benefit
possible hazard.
ions: If combined with other psy-
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er antidepressants may potentiate
n. Usual precautions indicated in
severely depressed, or with latent
ion, or with suicidal tendencies.
Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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MSMA

NEWS ROUND - UP

JULY, 1975

State malpractice hearings begin

Doctors from Kansas City and surrounding areas were told last week that "physicians in Missouri practice good medicine" and are paying for malpractice claims in other states.

Sen. Albert M. Spradling (D-Cape Girardeau), chairman of a Select Committee of the Missouri Senate studying the professional liability crisis in Missouri, congratulated Missouri doctors at the first two-day hearing. Approximately 100 physicians and others turned out to testify at the hearing.

Dr. R. Allen Chandler, MSMA President, outlined the Association's goals of seeking remedial legislation to change the present tort system and place professional liability on a more fair basis. He also pledged the cooperation of the MSMA in helping the Legislature develop meaningful laws to improve the current situation.

Kansas City Mayor Charles B. Wheeler Jr., a forensic pathologist, said the problem of medical malpractice not only affects the medical profession, but also the cities and counties would well be forced to pay higher premiums for insurance for their hospitals.

Dr. Warren F. Wilhelm, President of Jackson County Medical Society, pointed out that the increasing cost of malpractice coverage, just as any other overhead expense, will have to be made up through increased fees to patients.

Explaining that malpractice insurance woes are not limited to metropolitan areas, Dr. Richard Hedges, President of the Clay County Medical Society, stated that suburban and rural areas are also encountering large premium increases.

Dr. Michael J. Clarke, President of the Greene County Medical Society, said young physicians are reluctant to move to smaller towns because of the high cost of premiums to open a new practice.

Several other physicians presented testimony including Dr. Irving H. Clark, Kansas City, Chairman of the MSMA Commission on Medical-Legal Affairs; and Dr. Stanley S. Peterson, Springfield, senior MSMA Delegate to the AMA.

Other witnesses appeared on behalf of medical specialities, hospital groups and Blue Cross.

St. Louis hearings set

Missouri physicians, especially those in the St. Louis area, are urged to attend the second in a series of hearings on professional liability insurance scheduled July 22-23 in St. Louis.

Sen. Albert M. Spradling Jr., Chairman of a Select Committee of the Missouri Senate studying the malpractice insurance situation in Missouri, said the two-day hearing will be held at the Colony Hotel, 7730 Bonhomme in St. Louis.

Sen. Spradling said testimony from interested persons will be taken from 10 a.m. to 5 p.m. on Tuesday, July 22, and from 9:30 a.m. to 2 p.m. on Wednesday, July 23.

MSMA Headquarters understands that additional hearings will be held later in the year in Cape Girardeau and Jefferson City. No dates have been announced for these hearings.

Major bills pass Missouri General Assembly

Several bills of importance to physicians and their patients were passed during the recently completed Missouri General Assembly.

Fortunately, several other bills which would have adversely affected medical practice in Missouri did not gain final approval.

Perhaps the bill which received most attention by the press was SB 458 (Malpractice Insurance), which would allow an association such as the MSMA to establish a mutual-type malpractice insurance company. The bill was passed by wide margins and signed by the Governor.

Yet to be signed by the Governor at this writing is SB 1 (Surgicenter Licensing), which provides for licensing of ambulatory surgical centers by the Division of Health.

Still another bill which passed the General Assembly, SB 108 (Nurses Practice Act), has been vetoed by Gov. Bond. His veto message stated the bill did not comply with the "open meetings laws" and was in conflict with the Reorganization Laws passed last year.

Other bills which gained passage and have been signed into law include:

- HB 107 (Anatomical Gift Act) — This extends the

(Continued on Next Page)

Major bills

(Continued from previous page)

present law by allowing the printing of the Anatomical Gift Act on the reverse of Missouri driver's licenses.

- HB 70 (Health Facilities Act) — This creates the Health and Educational Facilities Authority which can help finance, build or lease health or educational facilities in the State.

- HB 578 (Child Abuse) — This strengthens the present Child Abuse Reporting Law and carried $7 million in federal funds.

- HB 642 (Ambulance Law) — This lowers the age requirement of ambulance drivers from 21 to 18 years old.

Two bills opposed by the MSMA which appeared to be in good position early in the Session, died before adjournment. These were HB 318 (Acupuncture), which would have allowed unqualified persons to practice acupuncture, and HB 342 (Chiropractic Expansion), which would have permitted chiropractors to use "heat, cold, water, sound and electricity" in their practice.

Other bills opposed by the MSMA which failed to gain passage included:

- HB 450 (Statue of Limitations) — This would have extended the present to two years from discovery, rather than the present two years from the act.

- SB 415 (Prescriptions Forms) — This would have required drug prescriptions to be issued on special triplicate forms provided by the Division of Health.

- SB 18 (Cardiology Technologists) and SB 432 (Ionizing Radiation Technologists) — These would have provided for licensing of these technicians while the MSMA prefers certification.

- HB 535 (Board of Healing Arts-Lay Member) — Would have replaced a physician member of the Board of Registration for the Healing Arts with a layman.

Many, many other bills of concern to medicine were considered by the Legislature and further reports will detail some of these. In all, the MSMA followed, to one extent or another, more than 110 bills during the last Session.

MMPAC address change

MMPAC
P.O. Box 9338
St. Louis, Missouri 63117

Manpower amendments backed

Missouri Representatives to the U.S. Congress were urged to support AMA amendments to HR 5546, the Health Manpower Bill, by Dr. R. Allen Chandler, President of the MSMA.

The amendments would remove a section of the bill that provides for federal control of medical residencies and delete a clause that would require medical students to either repay part of capitation grants to medical schools or serve in an area designated by the government.

AMA Delegates vote dues hike, revamp

In a momentous session, AMA Delegates have urged vigorous action in a number of medical problem areas — and approved a dues increase to $250.

Repeatedly emphasizing stronger AMA involvement in confronting problems facing local physicians and a revamping of AMA publication and economic aims, the House overwhelmingly passed the dues hike.

For details concerning issues at the AMA Convention, please read your June 23-30, 1975, AM News.

Of the eight resolutions introduced before the AMA House of Delegates by the Missouri Delegation, four of the resolutions were combined in substitute resolutions passed by the House. The substitutes passed were:

- Commend AMA on Utilization Review Law Suit — Commended the AMA Board for filing suit to halt implementation of forced utilization review and encouraged the Board to take similar action in the future on legislation or government regulations that threaten the physician's ability to provide quality care to his patients.

- Law Students and Medicine — Transmitted to the National Conference of Representatives of the AMA and the American Bar, a proposal for developing a symposia involving both medical and law students.

- SSA Eligibility Status — Instructed the Council on Medical Service to determine from the Social Security Administration's Bureau of Health Insurance how data necessary to determine eligiblity for Medicare benefits can be made available rapidly.

- PSRO — Local Control — Ordered AMA to direct its efforts in monitoring and evaluation PSRO's to in clude: 1) maximum autonomy in implementing PSRO at the local level; 2) greater flexibility in deciding on reimbursement policies; 3) support to PSRO's negotiat ing memorandums of understanding; 4) elimination of HEW transmittal letter as contract modifications; 5 where or other third party payors may date utilization review activities, or when inordinate amounts of time and/or responsibility are involved, physicians should be adequately compensated for their time and effort.

Missouri resolutions not adopted called for:

- Apply PSRO to Government Hospitals — Reference Committee said the VA is making efforts to install review mechanisms paralleling PSRO.

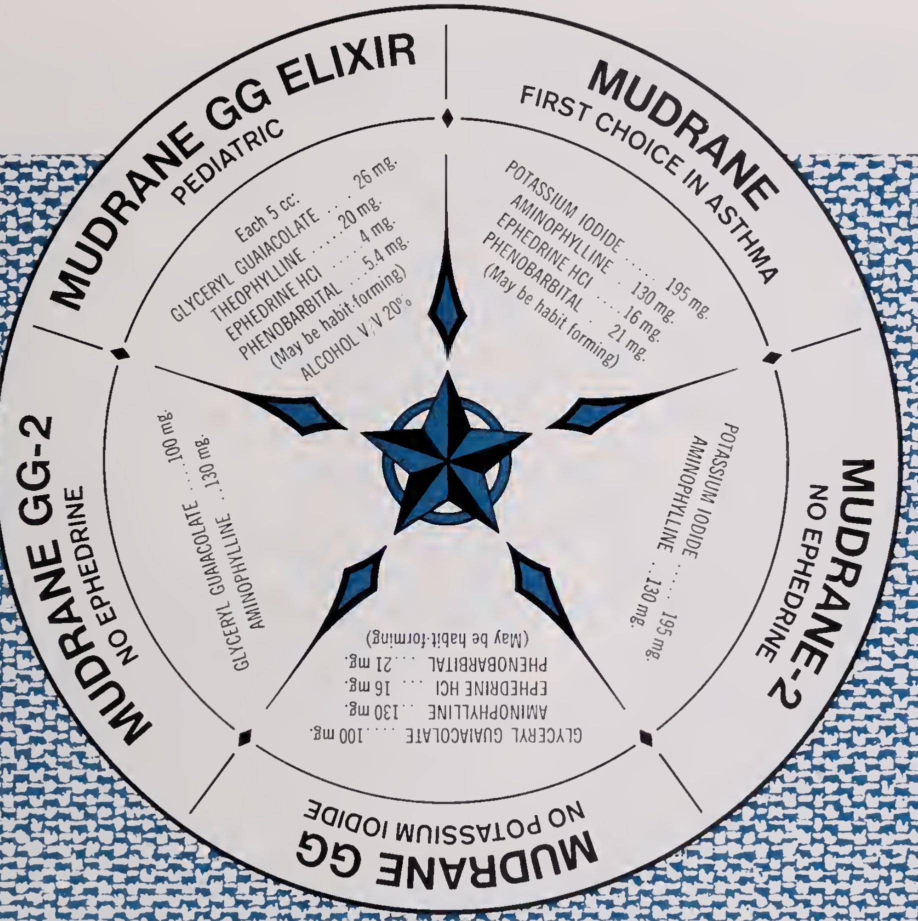
- Politics in VA Hospitals — This urged that all re quests by patients and veterans' representatives to Congressmen be sent directly to HEW without a form letter reply from the legislator. Committee said it is in appropriate for the AMA to instruct Congressmen on how to deal with their constituents.

- Advertising: HMO's — Resolutions would have had AMA re-evaluate stand allowing HMO's certain advertising. Committee pointed out that the HMO law specifically permits such organizations limited adver tising.

- AMA Fiscal Priorities — Resolution asked that more AMA economic resources be used in the legis lative, socioeconomic and field service areas by effect ing economics in elimination of non-vital publications Many of the points in this resolution were contained i other resolutions and report adopted by the House.

The MUDRANES

Discreet formulations of four well regarded drugs for the relief of bronchial distress—Potassium Iodide, Glyceryl Guaiacolate, Aminophylline, Ephedrine with Phenobarbital (to lessen cardiac stimulation).



MUDRANE
FIRST CHOICE IN ASTHMA
POTASSIUM IODIDE ..... 195 mg.
AMINOPHYLLINE . 130 mg.
EPHEDRINE HCl ... 16 mg.
PHENOBARBITAL . 21 mg.
(May be habit-forming)

MUDRANE-2
NO EPHEDRINE
POTASSIUM IODIDE ..... 195 mg.
AMINOPHYLLINE . 130 mg.

MUDRANE GG
NO POTASSIUM IODIDE
GLYCERYL GUAIACOLATE ....100 mg.
AMINOPHYLLINE ..130 mg.
EPHEDRINE HCl ... 16 mg.
PHENOBARBITAL ...21 mg.
(May be habit-forming)

MUDRANE GG-2
NO EPHEDRINE
GLYCERYL GUAIACOLATE .....100 mg.
AMINOPHYLLINE ..130 mg.

MUDRANE GG ELIXIR
PEDIATRIC
Each 5 cc:
GLYCERYL GUAIACOLATE .... 26 mg.
THEOPHYLLINE ..... 20 mg.
EPHEDRINE HCl ..... 4 mg.
PHENOBARBITAL ... 5.4 mg.
(May be habit-forming)
ALCOHOL V/V 20%

INDICATIONS: For the prompt symptomatic relief of bronchial asthma, emphysema and bronchiectasis. The Mudranes dilate the bronchi and liquefy mucus plugs. DOSAGE: Tablet; One tablet with a full glass of water 3 or 4 times daily as required. Divide tablet for child's dose. Elixir; Children, 1 cc for each 10 lbs. of body weight. May be repeated 3 or 4 times a day. Adult, one tablespoonful 4 times daily. All doses should be followed with a glass of water.

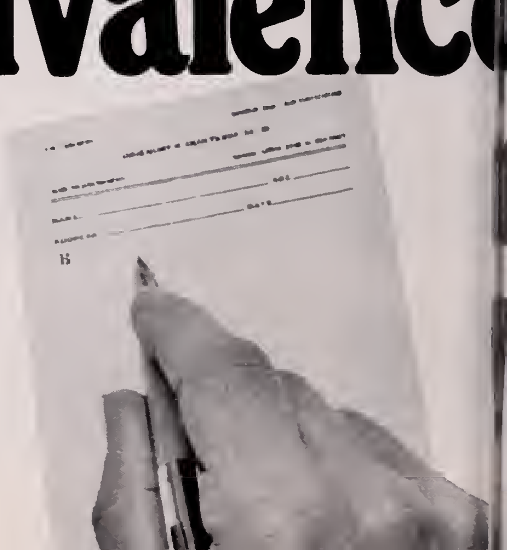
CONTRAINDICATIONS: Aminophylline/Theophylline is contraindicated in the presence of severe cardiac arrhythmias and patients with massive myocardial damage. Ephedrine, in presence of severe heart disease, extreme hypertension, and in hyperthyroidism. Phenobarbital, in porphyria and in patients with known phenobarbital sensitivity. Potassium Iodide, in pregnancy (to protect the fetus against possible iodine-induced depression of thyroid activity), in tuberculosis (produces gumma dissolution), and in acne; also in the presence of known iodide sensitivity. PRECAUTIONS: Aminophylline/Theophylline should be avoided in patients with massive myocardial damage and/or severe cardiac arrhythmias. In children, overdose may cause vomiting, cardiac arrhythmias, and severe agitation. Ephedrine should be used with caution in the presence of severe cardiac disease, particularly arrhythmias and angina pectoris; avoid in hyperthyroidism and severe hypertension. Phenobarbital may be habit-forming. Avoid overdosage. Potassium Iodide: Discontinue in the presence of skin rash, swelling of the eyelids and severe frontal headache. Long use may cause goiter. ADVERSE REACTIONS: Aminophylline/Theophylline may cause nausea, cardiac arrhythmias, and aggravate severe myocardial disease. It may cause headaches and tachycardia. Vomiting and dizziness are not uncommon. Ephedrine: In patients hypersensitive to CNS stimulation, ephedrine may cause nervousness, tachycardia, extrasystole and ventricular arrhythmias. May cause urinary retention, especially in the presence of partial prostatic obstruction. Psychoneurosis may be aggravated. Pre-existing anginal pain will be aggravated. Phenobarbital may produce severe skin rash. Avoid overdosage. May be habit-forming. Potassium Iodide may cause nausea. Over very long period of use, iodides cause goiter. Discontinue if patient develops skin rash, eye irritation, eyelid swelling, or severe frontal headache.

HOW SUPPLIED: Mudrane and Mudrane GG available in bottles of 100 and 1000 tablets; Mudrane-2 and Mudrane GG-2 in 100s; Elixir in pints and half-gallons.

Federal law prohibits dispensing without prescription.

WILLIAM P. POYTHRESS & COMPANY, INC., RICHMOND, VIRGINIA 23261

Bioequivalenc



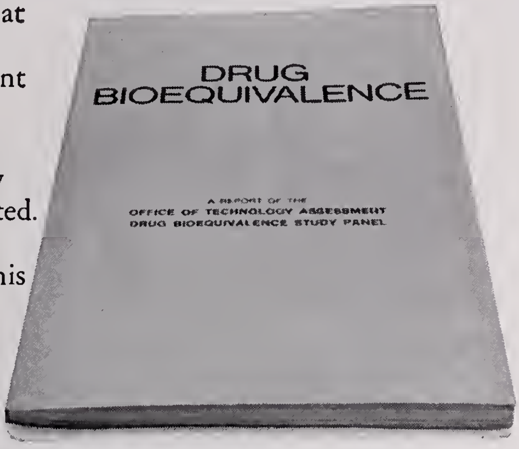
he weight of scientific opinion:

If the pharmacist substituted a micaly equivalent drug for the you have specified for your ient—could you be certain of that duct's safety and effectiveness ply because the chemical content the same?

Definitely not, unless bio- ivalence tests and other quality irance checks had been conducted. pharmaceutical industry and ny scientists have maintained this tion for years, but others have stioned it. Now the Office of nnology Assessment of the gress of the United States has orted on the issue in its Drug equivalence Study.*

Here are a few definitive state- ts in the O.T.A. report:

"...the problem of bioinequiva- y in chemically equivalent prod- is a real one. Since the studies in ch lack of bioequivalence was onstrated involved marketed lucts that met current compen- standards, these documented in- ces constitute unequivocal ence that neither the present dards for testing the finished luct nor the specifications for erials, manufacturing process, controls are adequate to ensure that ostensibly equivalent drug products are, in fact, equivalent in bioavailability.



DRUG
BIOEQUIVALENCE

A REPORT OF THE
OFFICE OF TECHNOLOGY ASSESSMENT
DRUG BIOEQUIVALENCE STUDY PANEL

"While these therapeutic failures resulting from problems of bioavailability were recognized and well documented, it is entirely possible that other therapeutic failures and/or instances of toxicity that had a similar basis have escaped attention."

The Pharmaceutical Manufacturers Association supports federal legislative amendments that would require manufacturers of duplicate prescription pharmaceutical products, subject to new drug procedures, to document:

(a) chemical equivalence; and
(b) biological equivalence, where bioavailability test methods have been validated as a reliable means of assuring clinical equivalence; or
(c) where such validation is not possible, therapeutic equivalence.

In addition, the PMA supports federal legislation that would require certification of all manufacturers of prescription products before they could start in business, annual inspections and certification thereafter, and strict adherence to FDA regulations on good manufacturing practices.

The overall quality of the United States drug supply is excellent. But only a total quality assurance program, envisaged in these and other policy positions adopted by the PMA Board of Directors in 1974, can bring about acceptable levels of performance by all prescription drug manufacturers and thereby assure the integrity of your prescription...

P·M·A
Pharmaceutical Manufacturers
Association
1155 Fifteenth Street, N.W.
Washington, D.C. 20005

*Copies of the complete report on Drug Bioequivalence may be obtained from the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402.

rotecting the ntegrity of our prescription

Must vasodilators and therapy for other diseases come into conflict?

not if the vasodilator is

VASODILAN®

(ISOXSUPRINE HCl)

the compatible vasodilator... no treatment conflicts reported

The cerebral or peripheral vascular disease patient often has coexisting disease[1] which calls for another drug along with his vasodilator. It may be a hypoglycemic, miotic, antihypertensive, diuretic, anticoagulant, corticosteroid, or coronary vasodilator.

Vasodilan is not incompatible with any of these drugs—no treatment conflict has been reported. And, unlike other vasodilators, Vasodilan has not been reported to affect carbohydrate metabolism, liver function, or intraocular pressure—or to complicate treatment of diabetes, hypertension, peptic ulcer, glaucoma, or liver disease.

In fact, there are no known contraindications to the use of Vasodilan in recommended oral doses, other than that it should not be given in the presence of frank arterial bleeding or immediately postpartum.

Indications: Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows:

Possibly Effective:

1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.
3. Threatened abortion.

Final classification of the less-than-effective indications requires further investigation.

Composition: Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg.

Dosage and Administration: 10 to 20 mg. three or four times daily.

Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

Adverse Reactions: On rare occasions, oral administration of the drug ha been associated in time with the occurrence of severe rash. When rash appears, the drug should be discontinued. Occasional overdosage effects such as transient palpitation or dizziness are usually controlled by reducing the dose.

Supplied: Tablets, 10 mg.—bottles of 100, 1000, 5000 and Unit Dose; 20 mg.—bottles of 100, 500 and Unit Dose.

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Mead Johnson LABORATORIES

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1. Gertler, M. M., et al.: Geriatrics *25*:134-148 (May) 1970.

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THE LAST WORD IN MEDICAL SUPPLIES.

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One contains aspirin.
One doesn't.

Darvocet-N® 100
100 mg. propoxyphene napsylate
and 650 mg. acetaminophen

Darvon®
Compound-65
65 mg. propoxyphene hydrochloride,
227 mg. aspirin, 162 mg. phenacetin,
and 32.4 mg. caffeine

Lilly

Additional information available to the profession on request.
Eli Lilly and Company, Inc., Indianapolis, Indiana 46206

500341

Volume 72, Number 7—July, 1975

Missouri Medicine

JOURNAL OF THE MISSOURI STATE MEDICAL ASSOCIATION

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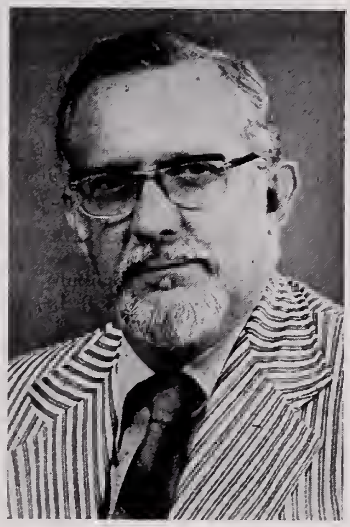
Remarks of James C. Cope, M.D., President



Mr. Speaker, Officers, Members of the House of Delegates:

Julius Caesar's report to the Roman Senate conerning parts of the Gallic Wars was presented in hree words: "Veni, Vidi, Vici." Translated this is I came, I saw, I conquered." Likewise was Admiral Perry's report of the Battle of Lake Erie: "We ave met the enemy and they are ours." When you an give a report like that it doesn't need much padding. It is with a great deal of pride that I can make a report to this House of Delegates that is almost as brief. During the past year, we have solved he malpractice crisis in Missouri and we have a eld service in operation.

Since this House of Delegates last convened, we ave a Field Secretary who is available to each ounty society and to each physician in the state. His purpose is to bridge the communication gap y bringing organized medicine closer to the practicing physician and the ideas of the practicing hysician closer to organized medicine. Those of ou who know Don Wilson know that he is actively working in the field. The plans are to have a second Field Secretary working with him by the first of the year. Our objective of having at least one physician–Field Secretary contact every six months is no longer a dream, but a strong probability. The response to the concept of an active field man has been strong and positive. I believe this response has more than vindicated your action last year when you reactivated the field service program.

We have, at least temporarily, solved the malpractice problem for Missouri physicians. Any member of the Association can obtain malpractice insurance from the Missouri State Medical Insurance Company, Incorporated. This For-Profit organization is totally owned by the Missouri State Medical Association. We have Rollins Burdick and Hunter of St. Louis as our broker and an underwriter with $2 billion in assets and $400 million in reserves. Details of the program will be made available at this meeting.

I do not believe that Medical Malpractice Insurance is more than an interim answer to our basic problem. Until more realistic avenues are developed, however, we are assured of protection. At

(Continued on page 325)

Remarks of R. Allen Chandler, M.D., President-Elect

Mr. Speaker, Officers, Members of the House of Delegates:

Many important issues which will require careful deliberation and decisions will come before this House of Delegates in the next four days.

Your decisions on these issues will determine the direction of your Missouri State Medical Association during the upcoming year and, indeed, for years to come. I am confident that this body will maintain its tradition of constructive actions which has established our Association as a rallying post for Missouri physicians and a guardian of the rights of our patients.

Several of the items before you deserve special mention and consideration.

I believe you will agree that the formation of the MSMI, Inc., our professional liability insurance company, is an outstanding accomplishment. To those many individuals and committees who worked so diligently on this tedious project, we all owe our sincere appreciation.

Now, however, the responsibility for the success of the MSMI transfers to our shoulders. It is *our* job to become involved in actively selling MSMI to our constituents back home. Significant participation in the company by MSMA members is a must if it is to serve us well. We know the alternative. We have watched premium rates soar and the selling market shrink.

We all will have several opportunities during this Annual Session to become well acquainted with the MSMI. The detailed report outlining the particulars of the company will be presented before the Reference Committee on Constitution and Bylaws. Also, representatives of Rollins Burdick Hunter Company, the agents-of-record, will be available to discuss the program at the MSMA Booth in the Exhibition Hall.

As you, your Officers and Councilors realize, the formation of the MSMI is *not* the total answer to the malpractice problem. Your Legislative Committee has already been instructed to study the situation thoroughly and prepare legislation to be introduced in the Missouri General Assembly.

We propose, with your support, to seek legislative relief in the areas of (1) graduated scale for contingent fees, (2) placing a ceiling on malpractice awards and, perhaps, most important, (3) providing for mandatory arbitration in malpractice cases. I would like to see the doctrine of informed consent be clarified by the Missouri Legislature.

Already, your Association has assisted in the establishment of a Select Committee of the Missouri Senate to consider the malpractice crisis and attempt to remedy the deteriorating situation. The senators on this Select Committee have exhibited great concern in our behalf and in the interest of our patients. I hope each of you will cooperate in any way possible with this Committee because the ultimate answer to the malpractice crisis lies in corrective legislation.

Other matters of serious concern to the medical profession include the seemingly endless number of federal laws and regulations emanating from Washington.

It is obvious that we are going to have to learn to live with some of these edicts. PSRO is a fact! The National Health Planning and Resources Act is a fact! We fought these measures and we lost. Even now, the AMA has proposed amendments for the PSRO Law which will make it a bit more pal-table. Also, the AMA has threatened to sue the overnment to prevent implementation of the Na- onal Planning Act. I support the AMA's moves holeheartedly and believe the MSMA should back e national Association in its efforts.

But, let's face it. These are now laws. Perhaps ey can be mellowed, but chances are that the con- epts they represent will remain in effect. There- re, we must provide *leadership* in the implemen- tion of these laws. We must be willing to pro- ide input into PSROs so that local norms and lo- l control prevail. We do not want HEW calling ll the shots. We also must take the *initiative* in the rly stages of the Planning Law. If it is over- rned, fine. If it is not, however, physicians must eak with authority on the establishment of re- ional health systems.

There are many more battles to be fought on e national legislative front including the most r-reaching of all—National Health Insurance.

Although passage of a National Health Insur- nce bill has been predicted for the past few years, consensus of opinion on the financing of the easure still has not been reached.

Personally, I cannot foresee passage of such a ill this year due to lack of consensus and, more nportantly, the ballooning federal budget. We mply cannot afford it. It is vital, however, that the ISMA closely monitor the Congress and give our rong support to the AMA's guidelines which ould preserve the private physician-patient rela- onship.

You will have the opportunity to exhibit addi- onal backing for the AMA during this Session hen you vote on the issue of Unified Member- ip.

I know that some of you may question the effec- veness of the AMA. But, and I paraphrase Dr. Ialcolm Todd, President of the AMA, what is ef- ctiveness? Is it the excellent score the AMA has ade on a battery of legislative tests? Is it a record that recently included getting HMO modified, discriminatory controls tabled, PSRO amendments sponsored and the Keogh Plan liberalized? Or, does the AMA have to score 100% to be considered effective? Let us recognize that no element in society has a perfect score. Let us recognize that any element has to set its sights *not* on the best of all possible worlds, but on the best of all possible realities. Let's recognize that in a world where medical freedom is the *exception* rather than the *rule*, the AMA . . . and the AMA alone . . . has maintained the *exception*.

Perhaps, the most *positive* feature physicians can point to when restrictive legislation is proposed is that we, more than any other profession or group, stress professional competence and improvement. I join President James C. Cope in congratulating the individuals responsible for developing MSMA's new voluntary plan of Continuing Medical Education and I pledge to encourage and implement this program by the January, 1976 deadline.

In reflecting the comments I have heard from several members, I, too, am enthusiastic about the new MSMA Field Service Department. Effective communication is the most difficult accomplishment for any association to achieve, and I feel that the Field Service will strengthen the bonds between the MSMA and its members. With an exploding number of issues constantly being brought before physicians, we must have the ability to provide one-to-one information to our members.

Our current budget was drawn up with the provisions for employing another Field Secretary. A complete study of the field-service needs will be carried out and implemented as required.

You who are here today and your constituents are members of the Missouri State Medical Association. Your ideas, problems and, yes, *solutions* are eagerly sought. Gentlemen and ladies, utilize your MSMA. Help your Association to better serve its members.

Report of
Mrs. George J. Lytton
President of the Woman's Auxiliary

Mr. Speaker, Dr. Cope, Delegates and Guests:

Thank you for this opportunity to report on the Woman's Auxiliary to the Missouri State Medical Association.

The theme this year has been "It is better to light one small candle than to curse the darkness." Many candles have been lit around the state.

Our major concern this year has been membership. Last year, we lost one delegate to the AMA Auxiliary convention. It is a pleasure to announce that we have regained that delegate by increasing our membership to 1,782 members.

Of course, the major objective of the Auxiliary is to extend the aims of the Missouri State Medical Association in its program for the advancement of medicine and public health.

To attain this objective, we are busy in many areas. Our contribution to AMA-ERF to date is more than $10,000. This total represents sales of products and Christmas cards, bake sales, garage sales, benefit shows, et cetera. We also support the Missouri State Medical Foundation, which will be at least $1,872 richer due to the efforts of our members. In addition, many county auxiliaries maintain scholarship programs for nurses and students in medically related fields. I did a little survey and discovered that $6,790 has been accrued among the various auxiliaries who do this type of scholarship work.

Community service by doctors' wives is a public relations program. These services cover areas such as volunteers for Meals-on-Wheels programs, support for teenage centers, blood pressure screening, a Dr. Dial program, blood donor recruitment, cooperation with other health agencies in staffing various mobile units for disease detection and working in local hospital auxiliaries. The MSMA Auxiliary also conducted a block survey for public health, health education needs and environmenta needs.

Doctors' Day is always observed by the Woman's Auxiliary. This is our opportunity to show appreciation for our doctors and to make communities aware of the contribution their physicians make Gov. Christopher Bond issued this proclamation declaring March 30 as Doctors' Day. I now would like to present this very pen with which he signed it to Dr. Cope. County medical auxiliaries honored their doctors by contributing to AMA-ERF and the Missouri State Medical Foundation, serving gourmet dinners to them, planting trees in their honor and giving them carnations.

Legislation is a vital area. County Legislation Chairmen have kept their auxiliaries aware of upcoming legislation, both state and national. Letters have been written by many members on medically related bills.

In October, we held a successful Fall Conference in Springfield. A *Quality of Life in the Late Years* panel presented an interesting glimpse of the sunset years. We were delighted to have Dr. John Matthews with us to bring us up to date on Legislation. This meeting also provides us with an opportunity to educate our county officers. State committee chairmen who had attended the North Central Regional Workshop gave inspiration to all those present.

As President, I have had the privilege of attend ng a Conference of all State Presidents and Presi- ents-Elect in Chicago, the AMA Leadership Con- erence, the Southern Medical Association conven- ion, several state conventions and, most important f all, meetings of 19 of our 24 county auxiliaries n Missouri. These county visits provide the com- unication between state and county auxiliaries nd prove that you Missouri doctors have terrific ives!

We are now ready for our Annual Meeting. One f the most important items on our agenda is the atification of an amendment to our Articles of ncorporation. This is necessary to make our not- or-profit corporation eligible for an IRS number. ur national guest is Mrs. Norman H. Gardner of onnecticut, who is the first Vice-President of the oman's Auxiliary to the American Medical Asso- iation.

It has been a pleasure to serve in this office. hank you for the opportunity to communicate ith the Medical Association through the pages of MISSOURI MEDICINE and for the privilege of attending Council meetings. The encouragement and understanding of Mr. Ray McIntyre and the staff has been most appreciated. We also are grateful for your support of *Missouri Doctor's Wife*, our quarterly bulletin which is mailed to every MSMA Auxiliary member.

There is another person who must be thanked for patience and understanding this year. We should make him an honorary member of the Woman's Auxiliary. He is my favorite psychiatrist, my husband.

If one little candle were lit by each Auxiliary member for her participation in programs, we would be able to light this room adequately for this meeting.

Just remember that behind every successful doctor, there is a surprised mother-in-law.

Greetings from all our members and best wishes for a great convention.

emarks of the President

ontinued from page 321)

is point, I wish to extend my personal thanks and e thanks of every member of the Missouri State edical Association, particularly to Dr. Howard McAlhany of Springfield, Dr. Irving H. Clark f Kansas City and Mr. Royal O. Cooper of our SMA Staff, who have really done the work to get is organization going.

These accomplishments should in no way eclipse e other work that has been done.

The Continuing Medical Education Program has dvanced and has been certified by the American edical Association. Dr. Paul Young, who deliv- red and nurtured the program, is leaving us and ill be Chairman of the Department of Family ractice at the University of Nebraska. Believe me, is has been a wonderful job that he has done.

Five PSRO areas covering the entire state have een designated and four of these have received lanning grants. While we may not agree in prin- iple with PSRO, we are at least prepared. The olicy manual has been developed and distributed. ach of you has received a copy. I know it has een read because I have heard from people who on't agree with everything in it.

The various committee reports you will consider at this meeting are hardly the agonized gasp of a moribund organization. They reflect the mature professional judgment of an effective society.

This ends my report, but I cannot leave the presidency of this Society without expressing my profound belief in the future of our profession and our Association.

I believe we will survive the attack by HEW. I also believe that in the end, we will prevail, once again becoming the masters of our own destinies. We must be united and I recommend the United Membership Program. We must be active in politics as good citizenship demands. We must remain alert to the intrusions and regulations of the Washington bureaucrats. Above all, it is imperative that we remain skillful and compassionate physicians.

At Armageddon, the last final battle will surely come when we will allow ourselves to be pushed no farther. Then, our sword and shield will be the love and gratitude of our patients.

Gentlemen, thank you for letting me be your President for the past year.

Minutes of the
117th Annual Session
MISSOURI STATE MEDICAL ASSOCIATION

House of Delegates
Chase-Park Plaza Hotel, St. Louis
April 17-20, 1975

FIRST SESSION

The First Session of the House was called to order at 1:30 PM on April 17, 1975 in the Khorassan Room with R. A. Slickman, Speaker, presiding. The following Officers, councilors and delegates were present during the 117th Annual Session:

Officers

President	James C. Cope, Columbia
President-Elect	R. Allen Chandler, Kansas City
Vice-President	James E. Campbell, Macon
Vice-President	Frederick J. McCoy, Kansas City
Vice-President	Robert A. Mayer, St. Louis
Secretary	John I. Matthews, Jefferson City
Treasurer	Donald R. Judd, St. Louis
Speaker of the House	R. A. Slickman, Kansas City
Vice-Speaker of the House	James T. Brown, Springfield
Immediate Past-President	E. A. Stricker, St. James

Councilors

1st District	John N. Martin, St. Joseph
2nd District	Lysle M. Bach, Hannibal
3rd District	Max S. Franklin, St. Louis
4th District	Louis P. Hetlage, Troy
5th District	Robert E. Bregant, Jefferson City
6th District	William D. Bradshaw, Clinton
7th District	Andrew McCanse, Kansas City
8th District	Howard J. McAlhany, Springfield
9th District	Claude W. Cooper, Thayer
10th District	Eugene T. Hansbrough, Poplar Bluff

DELEGATES

First District

Andrew	Warren C. Baker, Savannah
Buchanan	Allen I. Herman, St. Joseph
Buchanan	William B. Rost, St. Joseph
Buchanan	Donald J. Stallard, St. Joseph
Buchanan	Ernest E. Wadlow, St. Joseph
Clay	C. K. Fotopoulos, N. Kansas City
Clay	Donald E. Kuenzi, Kansas City
Clay	Truman B. Schertz, N. Kansas City
Clay	C. A. Stratman, Kansas City
Grand River	Ralph Bohnsack, Brookfield
Grand River	Thomas Cofer, Chillicothe
Grand River	John R. Dixon, Brookfield
Northwest Missouri	Troy Morgan, Albany
Northwest Missouri	Robert E. Dunshee, Maryville

Second District

Chariton-Macon-Monroe-Randolph	Floyd A. Barnett, Pari
Chariton-Macon-Monroe-Randolph	James E. Campbell, Maco
Chariton-Macon-Monroe-Randolph	G. R. Hudson, Moberl
Chariton-Macon-Monroe-Randolph	R. L. Bautista, Moberl
Lewis-Clark-Scotland	Landis Y. Davis, Canto
Marion-Ralls-Shelby	J. Russell Comer, Hanniba
Marion-Ralls-Shelby	Phillip B. Foreman, Hanniba
Marion-Ralls-Shelby	Carl R. Kruse, Palmyr
North Central	Francis Tarvydas, Edin
Pike	Lawrence Stuerman, Louisian

Third District

St. Louis City	L. B. Anglo, St. Loui
St. Louis City	Donald T. Behrens, St. Loui
St. Louis City	Ralph L. Biddy, St. Loui
St. Louis City	Morton A. Binder, St. Loui
St. Louis City	Albert G. Boldizar, St. Loui
St. Louis City	Leslie F. Bond, St. Loui
St. Louis City	Richard V. Bradley, St. Loui
St. Louis City	Robert Brookes, St. Loui
St. Louis City	Marshall B. Conrad, St. Loui
St. Louis City	Thomas J. Cooper, St. Loui
St. Louis City	Pablo de Ungria, St. Loui
St. Louis City	Joseph E. Edwards, St. Loui
St. Louis City	Richard H. Fallon, St. Loui
St. Louis City	Robert H. Felix, St. Loui
St. Louis City	Daniel M. Fraser, St. Loui
St. Louis City	Raymond O. Frederick, St. Loui
St. Louis City	August W. Geise, Jr., St. Loui
St. Louis City	Jerome Gilden, St. Loui
St. Louis City	Charles Gulick, St. Loui
St. Louis City	Lily A. Palmer-Hanes, St. Loui
St. Louis City	Donald R. Judd, St. Loui
St. Louis City	Jack Kayes, St. Loui
St. Louis City	Robert W. Kelley, St. Loui
St. Louis City	John J. Kelly, St. Loui
St. Louis City	Lawrence Lawton, St. Loui
St. Louis City	Leo LeBlanc, St. Loui
St. Louis City	Francis X. Lieb, St. Loui
St. Louis City	J. Otto Lottes, St. Loui
St. Louis City	Philip S. Luedde, St. Loui
St. Louis City	Robert R. MacDonald, St. Loui
St. Louis City	Robert N. Miller, St. Loui
St. Louis City	Michael G. Murphy, St. Loui

t. Louis City	Charles H. Nicolai, St. Louis
t. Louis City	Lawrence O'Neal, St. Louis
t. Louis City	Theodore Paletta, St. Louis
t. Louis City	F. E. Pennington, St. Louis
t. Louis City	Hubert A. Ritter, St. Louis
t. Louis City	Percival Salanga, St. Louis
t. Louis City	John S. Sciortino, St. Louis
t. Louis City	Charles S. Sherwin, St. Louis
t. Louis City	A. J. Signorelli, St. Louis
t. Louis City	James M. Stokes, St. Louis
t. Louis City	Clarence M. Turner, St. Louis
t. Louis City	Hugh R. Waters, St. Louis
t. Louis City	Carol F. Williams, St. Louis

Fourth District

ranklin-Gasconade-Warren	Samuel C. Bonney, Washington
ranklin-Gasconade-Warren	Harold F. Hoelscher, Warrenton
ranklin-Gasconade-Warren	George M. Workman, Hermann
efferson	Vicente D. Deles, Crystal City
t. Charles-Lincoln	Edward O. Damron, St. Charles
t. Charles-Lincoln	Paul H. Rother, St. Charles
t. Charles-Lincoln	John C. Soucy, St. Charles
t. Louis County	Vernon H. Balster, St. Louis
t. Louis County	C. Read Boles, St. Louis
t. Louis County	Rudolph E. Catanzaro, St. Louis
t. Louis County	Edwin J. Cunningham, St. Louis
t. Louis County	Robert B. Deitchman, St. Louis
t. Louis County	Allen P. Klippel, St. Louis
t. Louis County	Jules H. Kopp, St. Louis
t. Louis County	John M. Laird, Jr., St. Louis
t. Louis County	Robert A. Mayer, St. Louis
t. Louis County	Jerry N. Middleton, St. Louis
t. Louis County	Robert J. Meuller, St. Louis
t. Louis County	James R. Nakada, St. Louis
t. Louis County	Frederick D. Peterson, St. Louis
t. Louis County	Rudy Ruhling, St. Louis
t. Louis County	Melvin M. Schwartz, St. Louis
t. Louis County	James C. Sisk, St. Louis

Fifth District

udrain	Benjamin N. Jolly, Mexico
oone	W. C. Allen, Columbia
oone	George Fuchs, Columbia
oone	Kenneth K. Keown, Columbia
oone	Benedict A. Moranville, Columbia
oone	William B. See, Columbia
oone	Hugh E. Stephenson, Jr., Columbia
allaway	Henry Durst, Fulton
ole	Mary K. McCaffree, Jefferson City
ole	Kenneth K. C. Siu, Jefferson City
ole	Robert H. Tanner, Jefferson City
ooper	George W. Winn, Boonville
organ	J. Loren Washburn, Versailles

Sixth District

enry	Richard King, Clinton
hnson	T. Reed Maxson, Warrensburg
afayette-Ray	George K. Davault, Richmond
afayette-Ray	Robert R. Pavlu, Waverly
ettis	A. J. Campbell, Sedalia
aline	C. A. McBurney, Slater
est Central	Alfred W. Eklund, Pleasant Hill
est Central	R. L. Magee, El Dorado Springs
est Central	R. John Torontow, Nevada

Dr. Robert A. Slickman, Speaker of the House, declares the 117th Annual Session of the Missouri State Medical Association open as he calls the House of Delegates to Order.

Seventh District

Jackson	T. J. Bryant, Kansas City
Jackson	Barbara N. Buchanan, Kansas City
Jackson	Martin L. Crow, Kansas City
Jackson	Calvin E. Engelmann, Kansas City
Jackson	Robert C. Fairchild, Shawnee Mission, KS
Jackson	Fred D. Fowler, Kansas City
Jackson	Charles P. Gauthier, Kansas City
Jackson	Frederick H. Hartwig, Kansas City
Jackson	William D. Hoadley, Kansas City
Jackson	Harry S. Jonas, Independence
Jackson	Seymour J. Kranson, Independence
Jackson	Vance Link, Independence
Jackson	R. Stacy Long, Kansas City
Jackson	George J. Lytton, Kansas City
Jackson	Richardson K. Noback, Kansas City
Jackson	Mark D. Ost, Kansas City
Jackson	Milton B. Ozar, Kansas City
Jackson	O. Dale Smith, Kansas City
Jackson	David Tillema, Kansas City
Jackson	Edward J. Twin, Kansas City
Jackson	Herbert Waxman, Kansas City
Jackson	Warren F. Wilhelm, Kansas City
Jackson	Harry C. Wall, Kansas City
Jackson	George P. Williams, Kansas City
Jackson	James W. Willoughby, Kansas City
Jackson	S. Dwight Woods, Kansas City
Jackson	Ronald A. Youmans, Kansas City

Eighth District

Dallas-Hickory-Polk-Dade	O. A. Griffin, Jr., Buffalo
Greene	Walter A. German, Springfield
Greene	H. B. Ivy, Springfield
Greene	Henry C. Krahn, Springfield
Greene	Don Menchetti, Springfield
Greene	Stanley S. Peterson, Springfield

Greene	Thomas P. Sweeney, Springfield
Greene	Leo Wyrsch, Springfield
Jasper	John R. Esther, Joplin
Jasper	Marvin A. Singleton, Joplin
Jasper	Robert L. Willcoxon, Joplin
Ozark	George Blankenship, Neosho
Ozark	R. R. Donley, Monett
Ozark	F. R. Esparrago, Monett
Ozark	Kenneth Glover, Mt. Vernon
Ozark	Arthur Graves, Mt. Vernon
Ozark	Roy E. Kenney, Neosho
Webster	T. M. Macdonnell, Marshfield

Ninth District

Mid-Missouri	B. J. Bass, Salem
Mid-Missouri	Bernard Draper, Rolla
Mid-Missouri	Earl E. Feind, Rolla
Mid-Missouri	Rae W. Froelich, Lebanon
South Central	Marvin L. Fowler, West Plains
South Central	James A. Hasek, Mountain Grove
South Central	Joe L. Spears, Cabool
South Central	Jack N. Wiles, West Plains

Tenth District

Butler-Wayne-Ripley-Carter	Fred Caldwell, Poplar Bluff
Butler-Wayne-Ripley-Carter	George H. Ladyman, Poplar Bluff
Butler-Wayne-Ripley Carter	T. Eugene Ruff, Poplar Bluff
Butler-Wayne-Ripley-Carter	Kirkby L. Turner, Poplar Bluff
Cape Girardeau	John K. Holcomb, Cape Girardeau
Cape Girardeau	Melvin C. Kasten, Cape Girardeau
Cape Girardeau	Harold B. Rapp, Cape Girardeau
Dunklin	R. I. Santos, Kennett
Mineral Area	Charles W. Chastain, Farmington
Mineral Area	A. R. Rao, Fredericktown
Mineral Area	David Wilson, Potosi
Perry-Ste. Genevieve	Alfred E. McDermott, Perryville
SEMO	Edwin J. Masters, Advance
SEMO	John P. Sargent, Sikeston
SEMO	William C. Shell, Sikeston
SEMO	Gregario Rodriguez, Charleston

DELEGATES-AT-LARGE

Speaker and Vice-Speaker of the House of Delegates

R. A. Slickman, Kansas City, Speaker
James T. Brown, Springfield, Vice-Speaker

Past-Presidents

Victor B. Buhler, Kansas City
Joseph L. Fisher, St. Joseph
Walter T. Gunn, St. Louis
David N. Kerr, St. Louis
Doyle C. McCraw, Bolivar
Guy N. Magness, University City
Gerald L. Miller, Kansas City
E. A. Stricker, St. James
Byron M. Stuart, Boonville
Paul Whitener, St. Ann

STUDENT DELEGATES

Mr. Michael Fredrich, University of Missouri-Columbia School of Medicine
Mr. Dennis Nicks, University of Missouri-Columbia School of Medicine
Mr. Mark C. Kasten, University of Missouri-Kansas City School of Medicine
Mr. Thomas E. Miles, Jr., St. Louis University School of Medicine
Mr. Alan Umbright, St. Louis University School of Medicine
Mr. Lyle Koen, Washington University School of Medicine
Mr. Stuart Myers, Washington University School of Medicine

The invocation was given by James C. Cope, M.D., President of the Missouri State Medical Association.

Dr. George J. Lytton presented the report of the Credentials Committee. He stated that satisfactory credentials had been presented by 130 delegates. He informed the House that this number of delegates constitutes a quorum and dispensed with a roll call.

Dr. Max S. Franklin, Chairman of the Committee on Arrangements, welcomed the Association members, their wives and guests to the 117th Annual Session and expressed hope for a successful meeting.

The Speaker announced that Dr. Paul Max, who had accepted the invitation to serve as Parliamentarian for the House of Delegates, was unable to attend the meeting. He then introduced Dr. Charles Sherwin as Parliamentarian.

The minutes of the 116th (1974) Annual Session, which were published in the July 1, 1974 issue of Missouri Medicine, were approved as published.

The Speaker announced appointment of the following reference committees and presented his instructions to the committees:

CONSTITUTION AND BY-LAWS

E. J. Cunningham, St. Louis, Chairman
J. Otto Lottes, St. Louis
Kenneth K. C. Siu, Jefferson City
Robert L. Willcoxon, Joplin
William D. Hoadley, Kansas City

MEDICAL EDUCATION AND PUBLIC WELFARE

Thomas J. Cooper, St. Louis, Chairman
Calvin E. Engelmann, Kansas City
Kirkby L. Turner, Poplar Bluff
Samuel C. Bonney, Washington
William B. Rost, St. Joseph

MISCELLANEOUS AFFAIRS

James E. Campbell, Macon, Chairman
Benjamin N. Jolly, Mexico
Don Menchetti, Springfield
John J. Kelly, St. Louis
Melvin C. Kasten, Cape Girardeau

NECROLOGY

C. K. Fotopoulos, N. Kansas City, Chairman
Rudy Ruhling, St. Louis
R. L. Magee, El Dorado Springs
Marvin L. Fowler, West Plains
Kenneth Glover, Mt. Vernon

REPORTS OF OFFICERS

Leo Wyrsch, Springfield, Chairman
Hugh E. Stephenson, Jr., Columbia
Donald T. Behrens, St. Louis
T. J. Bryant, Kansas City
John C. Soucy, St. Charles

RESOLUTIONS

Harry S. Jonas, Independence, Chairman
Francis X. Lieb, St. Louis

W. Chastain, Farmington
ichard King, Clinton
ernard Draper, Rolla

The Speaker introduced Dr. Cope who delivered the an- ual President's Message.

(The President's Message is published on page 321.)

The Speaker then asked Dr. R. Allen Chandler to present ie annual message of the incoming President.

(Dr. Chandler's address is published on page 322.)

(Both Presidential messages were referred to the Refer- nce Committee on Reports of Officers.)

The Speaker then invited Mrs. George J. Lytton to pre- :nt the annual report of the President of the MSMA Wom- n's Auxiliary.

(Mrs. Lytton's request is published on page 324. It was ferred to the Reference Committee on Reports of Offi- ers.)

The Speaker introduced Mrs. William R. McPhee, Presi- ent-Elect of the Woman's Auxiliary to the MSMA.

The Speaker then introduced Frank J. Jirka, Jr., M.D., a iember of the Board of Trustees of the American Medical ssociation, who was a distinguished guest at the Annual ession. Dr. Jirka, who also is a Past-President of the Illinois tate Medical Association, addressed the House of Dele- ates.

The Speaker stated that the reports of the Health Care oundation of Missouri, Officers, Committees, Commissions nd Council were published in the Delegates Handbook and eferred the reports to the appropriate reference commit- ees. He asked for any supplementary reports from commit- e and commission chairmen. There were no supplementa- reports.

The Speaker then requested any supplementary report of ie Council. He referred the various subjects within the upplementary Report of the Council to appropriate refer- nce committees.

(This report is published on page 369).

The reports of the Health Care Foundation of Missouri, fficers, Committees, Commissions and Council are as fol- ws:

REPORT OF THE HEALTH CARE FOUNDATION F MISSOURI AND HCFM/PSRO SUPPORT CENTER

Calendar year 1974 was a dynamic period in the history the Health Care Foundation of Missouri. During the year, tensive reorganization occurred; PSRO implementation as commenced; regional peer review activities were tem- orarily suspended; new Articles and Bylaws were ap- roved; new additions were made to the HCFM Board; and ew directions were charted for future years relative to both ie public and private sector review framework.

December, 1973, marked the completion of the three- ear terms of office of Hector W. Benoit, Jr., M.D., Chair- ian, and Gerald L. Miller, M.D., Director. Because of nu- ierous other commitments, both asked that they not be con- dered for renomination to the HCFM Board. These vacan- ies were filled by Alfred D. Biggs, Jr., M.D. (Kansas City) nd Clement B. Grebel, M.D. (St. Louis).

At the first 1974 Board meeting in March, the following fficers were elected:

Clement B. Grebel, M.D., Chairman (St. Louis)
Eugene W. Egle, D.O., Vice Chairman (St. Louis)
Claus A. Rohweder, D.O., Secretary (Kirksville)
John I. Matthews, M.D., Treasurer (Jefferson City)

Other members of the Board were the following:

Joseph L. Fisher, M.D. (St. Joseph)
John M. Fry, D.O. (Mt. Vernon)
Francis M. Maple, M.D. (Springfield)
Alfred D. Biggs, Jr., M.D. (Kansas City)
Joseph B. Vacca, M.D. (St. Louis)

With PL 92-603 implementation becoming increasingly imminent, the Board took immediate steps to establish a Reorganization Advisory Committee comprised of physicians from each of the five PSRO areas which had been designated by DHEW. Members of this committee were selected by the county medical societies, osteopathic organizations and other local organizations and these representatives met with the Board at this first meeting. The members of this committee were the following:

R. Donald Blim, M.D. (Kansas City)
C. Y. Thomas, M.D. (Kansas City)
Robert E. Bregant, M.D. (Jefferson City)
James G. Miller, D.O. (Jefferson City)
Herbert Rosenbaum, M.D. (St. Louis)
John L. Burroughs, D.O. (St. Louis)
Joseph E. Blinn, D.O. (Marshfield)
Walter A. German, Jr., M.D. (Springfield)
W. A. Rohlfing, D.O. (Flat River)
Charles P. McGinty, M.D. (Cape Girardeau)

The Reorganization Advisory Committee was co-chaired by Drs. Matthews and Maple. The recommendations of the committee to the Board were:

"Drs. Matthews and Maple reported for the Reorganization Advisory Committee. It was the unanimous decision that a unified statewide organization representing all areas would be desirable both for the long and short run. Discussion was entered into briefly that somewhere along the line the Federal Government might withdraw support for this type of statewide organization and then turn the function of this organization over to the PRC. With this action in mind and as a protection for the future, consideration should be given to developing membership for the organization. The committee felt the statewide organization could fulfill the following roles:

Dr. Max S. Franklin, Chairman of the Committee on arrangements, officially welcomes the MSMA members, their wives and guests to the 1975 meeting in St. Louis.

1. Final adjudication with an appeal mechanism
2. Education
3. Statistical support—research and development
4. Negotiate statewide contracts, principally HIC contracts
5. Negotiate HEW and other agency contracts
6. Activities confined to physician function
7. Liaison with MSMA and MAOPS
8. Support functions for regional PSRO and private sector peer review.

"The committee tentatively recommended a 13-member board composed of:

Two representatives from each PSRO area and with two alternates (with two votes from each area) (10)
One MHA (M.D. or D.O.)
One MAOPS
One MSMA"

It also was decided at this time that with the reorganization of the HCFM, a moratorium on review of cases by the regional panels be declared until such reorganization was complete and PSRO responsibilities were clearly defined.

In April, the HCFM responded to a "Request for Proposal" from DHEW relative to becoming established as the statewide PSRO Support Center for Missouri. Two months later, the HCFM secured a contract for the period June 27, 1974-December 27, 1974. The primary responsibilities of the HCFM under this contract were to assist in the development of local PSR Organizations; to assume statewide responsibilities for informing and educating physicians on the PSRO program; to establish the appropriate liaison with other statewide physician and health-oriented organizations; and to provide services needed by each developing PSRO Area Organization. Dr. Grebel, as chairman, was designated as the Project Director for this contract. Four of the five areas formed physician groups and applied for Planning Contracts at this same time.

To better define and strengthen the liaison between the HCFM/PSRO Support Center and the area organizations, the Articles and Bylaws of the HCFM were rewritten to include three physician representatives from each PSRO area on the Support Center Board of Directors plus two physician representatives, one each from MSMA and MAOPS. The new Articles and Bylaws were approved by the Administrative Members and filed with the Secretary of State in October. This action officially changed the name of the HCFM to the *HCFM/PSRO Support Center.* The reorganization under the new Bylaws was accommodated and a new Board of Directors was established. The representatives appointed by the respective organizations to the new Support Center Board were the following:

AREA I—Northwest Mo/PSRO
Phillip L. Accardo, D.O. (Independence)
Alfred D. Biggs, Jr., M.D. (Kansas City)
Joseph L. Fisher, M.D. (St. Joseph)

AREA II—Mid-Missouri PSRO Foundation
Jack A. Auxter, D.O. (Kirksville)
Robert E. Bregant, M.D. (Jefferson City)
Byron M. Stuart, M.D. (Boonville)

AREA IV—MOAF, Inc.
Andrew J. Fritsch, M.D. (Joplin)
Francis M. Maple, M.D. (Springfield)
E. L. Williams, D.O. (Springfield)

AREA V—SEMO PSRO
Max A. Heeb, M.D. (Sikeston)
Charles P. McGinty, M.D. (Cape Girardeau)
W. A. Rohlfing, D.O. (Flat River)

MISSOURI STATE MEDICAL ASSOCIATION
Clement B. Grevel, M.D. (St. Louis)

MISSOURI ASSOCIATION OF OSTEOPATHIC PHYSICIANS AND SURGEONS
Claus A. Rohweder, D.O. (Kirksville)

The *Area III* PSR Organization (CEMPROC) opted not to appoint its representatives to the Support Center Board at this time. Although the Support Center Board regretted the CEMPROC decision, it authorized the Support Center to continue communications and to provide services as requested. Three vacancies on the Board will be maintained for their representatives.

The officers elected by the new Board were the following:

Clement B. Grebel, M.D., Chairman (St. Louis)
Claus A. Rohweder, D.O., Vice Chairman (Kirksville)
Robert E. Bregant, M.D., Secretary (Jefferson City)
Francis M. Maple, M.D., Treasurer (Springfield)

Under the reorganized structure, the HCFM/PSRO Support Center has no individual physician members, but only institutional members. Individual physicians are represented on the HCFM/PSRO Support Center Board through their local PSRO area organization and through MSMA and MAOPS.

During the last six months of 1974, the HCFM/PSRO Support Center devoted its entire effort to fulfilling its Support Center contract and working with the individual PSRO area organizations. New offices for the HCFM/PSRO Support Center have been acquired at 1907 William Street in Jefferson City in order to permit expanded organization and services.

Collateral with the actions recommended by the Reorganization Advisory Committee to the HCFM in March, 1974 the Board proceeded to address the needs of private sector review and formalized the organizational concept of the Association of Missouri Peer Review Organizations. This organization would parallel the PSRO structure and would be implemented at some future date depending upon how the issues of National Health Insurance and expanded PSRO review processes develop. If implemented, AMPRO would probably perform a coordinative role for the private sector review organizations in each review area. The major services that would be provided by AMPRO would be the establishment of an appropriate appeal mechanism, education, statistical support, research and development, negotiation of statewide contracts with HIA organizations and government agencies for review activities or research, and providing whatever supportive services may be needed by the individual area organizations. Articles of Incorporation for AMPRO were also drafted for future action.

What does the future hold? These are traumatic times in medicine, and no one can predict the directions that government, physician organizations, consumer groups or the health insurance industry may take. One thing is certain however. The HCFM/PSRO Support Center will continue to do its utmost to see that the major focus of its involvement remains on quality assurance and true professionalism in program management.

Clement B. Grebel, M.D

(Referred to the Reference Committee on Resolutions.)

Reports of Officers

REPORT OF THE SECRETARY

The Missouri State Medical Association had 4,672 members as of Dec. 31, 1974. This was an increase of 203 members over the previous year.

MEMBERSHIP CHANGES DURING THE YEAR

embers, Jan. 1, 1974		4,469
New Members admitted during year	339	
Reinstated	21	
Total added	360	
Members dropped during year	31	
Deceased	69	
Transferred to other states	42	
Resigned	15	
Total lost	157	
Net Gain		203
embers, Dec. 31, 1974		4,672

The Committee on Nominations, which is appointed by e President from the House of Delegates, must submit minations for the following offices:

Three Vice-Presidents to fill the expired terms of Robert . Mayer, St. Louis; James E. Campbell, Macon; Frederick McCoy, Kansas City.

A Speaker of the House of Delegates and a Vice-Speaker the House of Delegates to fill the expired terms of Robert . Slickman, Kansas City, Speaker, and James T. Brown, ringfield, Vice-Speaker.

Two Delegates and corresponding Alternates to theAmeran Medical Association to fill the vacancies created by the piration on Dec. 31, 1975, of the terms of Delegate, Hecr W. Benoit, Jr., Kansas City; Alternate, Hugh E. Stephenn, Jr., Columbia; Delegate, Hubert A. Ritter, St. Louis; Alrnate, Lawrence W. O'Neal, St. Louis.

The terms (two years) of the Councilors of the even mbered districts expire this year. These Councilors are ysle M. Bach, Hannibal, Second District; Louis P. Hetlage, roy, Fourth District; William D. Bradshaw, Clinton, Sixth istrict; Howard J. McAlhany, Springfield, Eighth District; ugene T. Hansbrough, Poplar Bluff, Tenth District. Deletes from these districts shall meet during the meeting ior to the last day and elect the Councilor for their disict. The election shall be certified to the House of Deletes on a prescribed form which will be furnished.

The entire session will be held in the Chase-Park Plaza otel in St. Louis. The House of Delegates will hold its first ssion on Thursday, April 17 at 1:30 PM in the Khorassan oom. Reference Committees will meet in committee rooms the hotel. The second session of the House of Delegates ill convene at 4 PM on Friday, April 18 in the Khorassan oom. The final session of the House, a breakfast meeting, ill be held in the Khorassan Room at 7:30 AM on Sunday, pril 20.

Registration facilities will be open on Thursday, April 17, om 11 AM to 4 PM; on Friday and Saturday from 8 AM to PM, and on Sunday from 7:30 AM to 9 AM. Registration ill be in the Regency Room.

John I. Matthews, Secretary

(Referred to Reference Committee on Reports of Offirs.)

REPORT OF THE TREASURER

The report of the Treasurer is covered in the Financial atement which appeared in the March issue of Missouri edicine and is included elsewhere in the Delegates' Handok. Therefore, it is not repeated here.

Donald R. Judd, Treasurer

(Referred to Reference Committee on Reports of Offirs.)

REPORT OF THE EXECUTIVE SECRETARY

Annual Sessions of the Missouri General Assembly, now ing held, are considering a large number of legislative bills each year affecting medicine. A great amount of time is spent by some members of your staff in following these bills, scheduling physicians to appear before committees of the Legislature and in educational activities relating to these bills.

Continuous contact is maintained with Missouri's ten members of the U. S. House of Representatives and with our two U. S. Senators on specific Health Legislation on the federal level. The Association's Legislative Committee and Council direct overall staff activities in the legislative area of health-related bills.

We were very sorry to lose the services of Tom Fox who retired on March 31, 1974. Mr. Ron Ellison was employed in the position vacated by Mr. Fox.

Mr. Don Wilson was employed as MSMA Field Secretary in September of 1974. Don is devoting much of his time to consultations with County Medical Society officers and MSMA members throughout the state. His prime responsibility will be to help keep MSMA members informed on current information and services available from MSMA Headquarters and AMA Headquarters. In turn, he will convey the input of county societies and members back to MSMA Headquarters regarding Association policies and services. He will also be in position to increase past staff activities in assisting physicians seeking locations to find such and communities to find physicians.

Foreign tours for members of MSMA continue to be a part of the Association's activities program. Information on such tours is sent by *special mailing* to members from time to time and discussed in various issues of Missouri Medicine.

Since the 1974 MSMA Annual Session, some members of the staff have spent much time working with and under the direction of the Association's Ad Hoc Committee on Malpractice Insurance. This Committee has kept the Council informed on its activities in proposing and developing a group program for members of the Association. This activity, along with other projects and programs of various committees, commissions and the Council are reported through the written reports in your Delegates' Handbook and in Missouri Medicine.

An MSMA Policy Manual has been developed and is being mailed to all members with their 1975 membership Pocket Card. This manual states the official position of MSMA on many important, relevant issues.

I again take this opportunity to express my sincere appreciation and thanks to all of your State Association Headquarters staff for their cooperation and diligent service.

Raymond McIntire, Executive Secretary

(Referred to Reference Committee on Reports of Officers.)

Reports of Standing Committees

REPORT OF THE COMMITTEE ON CONSTITUTION AND BYLAWS

If Resolution #40 providing for Unified Membership with the AMA is adopted at the first session of the House of Delegates at the 1975 Annual Meeting, the Committee suggests the following necessary changes in the Constitution and Bylaws:

1. Amend the Constitution of the Missouri State Medical Association by striking out "Article III. Membership" and inserting in lieu thereof the following:

> "Membership in this Association shall be limited to and include all members in good standing in component societies which hold charters from this Association and

In his remarks to the House of Delegates, President James C. Cope stated, "I cannot leave the presidency of this society without expressing my profound belief in the future of our profession and our Association."

who are members in good standing of the American Medical Association."

2. Amend the Bylaws of the Missouri State Medical Association as follows: Amend "Chapter I. Membership" by striking out all of Section 1 of Chapter I and inserting in lieu thereof the following:

> "Section 1. Members of this Association shall be physicians whose names have been certified by secretaries of component societies to the Secretary of this Association that they are duly elected members of a component society and are legally qualified physicians practicing in Missouri and are members of the American Medical Association except as otherwise provided. Each member must be of good moral and professional standing, and must not support, nor practice, nor claim to practice any exclusive system of medicine."

3. Amend Chapter VIII, Section 1 (a) of the Bylaws by striking out Section 1 (a) of Chapter VIII and inserting in lieu thereof the following:

> "Section 1. (a) The annual dues of this Association shall be $90.00, which shall be applicable to each active member of the Association beginning in 1975 and shall be levied per capita on the active members of the component societies; the per capita levy for junior members shall be $10.00 per year; honor and associate members shall not be required to pay dues. Dues shall be payable on January 1 of the year for which they are levied. Any forgiveness of the dues and assessments of the AMA shall be in accordance with rules and regulations of that Association."

4. Amend Chapter VIII, Section 4, of the Bylaws by striking out Section 4 of Chapter VIII and inserting in lieu thereof the following:

> "Section 4. The Secretary of each component society shall cause to be collected and remitted to the Treasurer of this Association the dues and capita levies of this Association and the dues and assessments of the American Medical Association. Any member whose name has not been reported for enrollment and whose dues, capita levies of this Association and dues and assessments of the American Medical Association have not been remitted to the Treasurer of this Association on or before March 1 of each year shall stand suspended until his name is properly reported and his dues, capita levies and assessments for the current year are paid. On December 31 of each year, members delinquent in payment of such dues and assessments, or any part thereof shall, ipso facto, forfeit their memberships. No suspended member shall be eligible to register at an annual session."

The Committee on Constitution and Bylaws submits the amendments outlined above to implement the unified membership resolution if it is adopted.

During the May Council meeting, it was proposed that it might be advisable to consider a change in the Constitution and Bylaws to permit a Vice-Councilor in each district and the following motion was made:

"The Council requests the standing Committee on Constitution and Bylaws to investigate the manner and means of changing the Constitution and Bylaws to permit the election of a Vice-Councilor from each district and to report their findings to the Council at the January Council Meeting."

The Committee on Constitution and Bylaws notes and commends the Councilors for their excellent attendance record at Council meetings. At present, the Council consists of 15 members. An addition of ten Vice-Councilors woul bring this number to 25, and the Committee felt it would be quite cumbersome for the Council to accomplish its wor with such a large number of people.

It is recommended that the MSMA Council adopt its ow mechanism to provide for someone to represent the Councilor District in the absence of the elected Councilor. Th Committee recommends that if a Councilor knows he wil be unable to attend a meeting, he may be allowed to designate a physician from his District to represent him durin the Council meeting. This designated representative coul discuss and present the views of the Councilor District o all issues, but would not have the right to vote. This designated representative could then meet and discuss the activities of the Council meeting with the Councilor.

Resolution #5—MSMA Parliamentary Procedure—It i recommended that Resolution #5 introduced in the 197 House of Delegates be re-referred to a Reference Committee during the 1975 Annual Session. If after hearing testimony in support of this resolution the Reference Committee recommends adoption of *Sturgis Standard Code of Parliamentary Procedure* in lieu of *Roberts Rules of Order* an if the House of Delegates adopts the recommendations o the Reference Committee, the Committee on Constitutio and Bylaws recommends the following change in the Bylaws:

> "Chapter X. Rules of Order. The deliberations of this Association shall be conducted in accordance with parliamentary usage as defined in *Sturgis Standard Code of Parliamentary Procedure.*"

This resolution was originally introduced at the 197 House of Delegates. During the Reference Committee hearing, no testimony was presented. The Reference Committe did not feel that it understood the issue and recommende that this be referred to the Committee on Constitution an Bylaws. The Constitution and Bylaws Committee recommends that this subject be re-referred to the Reference Com ittee as outlined above.

JOSEPH CONRAD, Chairman
DONALD R. JUDD
R. STACY LONG
FREDERICK D. PETERSON
EDWIN M. POWELL

(Referred to the Reference Committee on Constitution Bylaws.)

REPORT OF COMMITTEE ON PUBLICATIONS

The 71st volume of MISSOURI MEDICINE was completed ith the publication of the December, 1974 issue. During he year, 13 issues were printed and distributed. Eleven of hese issues contained scientific pages, special articles, or-anizational reports, monthly messages from the presidents f the Association and Woman's Auxiliary and news and ther items of interest to members of the medical profession. he July 15 issue was the annual Membership Directory. he July 1 issue contained the official proceedings of the 974 (116th) Annual Session of the MSMA House of Dele-ates.

There were two special issues of the Journal. The scien-fic articles in the April issue were contributed by members f the faculty of the University of Missouri-Columbia School f Medicine and the articles in the December issue were ontributed by members of the staff at the Ellis Fischel tate Cancer Hospital and Cancer Research Center.

In the November issue, MISSOURI MEDICINE published the econd major data collection and analysis effort of the Mis-ouri Center for Health Statistics, which is jointly sponsored y the State Board of Health and the Governor's Advisory ouncil for Comprehensive Health Planning. After publica-on in the Journal, the study was reprinted in booklet form y the Missouri Division of Health for further distribution.

During the year, 42 scientific manuscripts and eight spe-ial articles were published. Most of the articles were writ-en by Missouri authors.

The total number of journal pages in 1974 was 142 less an the total for 1973. The reduction was made in an ef-ort to adjust to the inflationary costs of printing and paper nd to the decline in national advertising revenue during the ear.

Following is a comparative report for 13 issues:

	1973	*1974*
Journal Pages	848	706
Advertising Inserts	51	31
MSMA Inserts	11	12
Total Insert Pages	230	138
Total Pages	1,078	844

The Editors wish to express appreciation to all authors ho submitted scientific manuscripts and to all other indi-iduals, institutions and organizations for their valuable con-ibutions. This includes the administrations, faculties and ublications departments of the University of Missouri chools of Medicine in Columbia and Kansas City, St. Louis niversity, Washington University and Ellis Fischel State ancer Hospital and Cancer Research Center.

At the year's end, the Journal circulation was 5,111. The omplete financial report for the Journal is included in the nancial statement for the Missouri State Medical Associa-on for the year 1974. The report was published in the arch, 1975 issue of MISSOURI MEDICINE and is included n the Delegates' Handbook.

JOSEPH V. FINNEGAN, Chairman
WILLIAM C. MIXSON
CHARLES S. SHERWIN
BYRON M. STUART
WILFRED E. WOOLDRIDGE

(Referred to Reference Committee on Reports of Officers.)

REPORT OF COMMITTEE ON LEGISLATIVE AFFAIRS

Following the trend of the federal government, the General Assembly is becoming more and more interested in medical and health-related issues. As a result, the Committee on Legislative Affairs has found it necessary to become involved in a growing number of legislative measures.

Preceding the current Legislative session, the Committee considered appropriate legislation and secured sponsors to introduce bills. Also, decisions were made to oppose some bills and arrangements were drawn up to most effectively present our opposition.

Of the approximately 1,400 bills introduced in both Houses of the General Assembly, 35 Senate bills and more than 80 House bills are being watched to various degrees by this Committee. On many of these measures, we have provided experts to testify either for or against.

The Committee would like to express its appreciation to those MSMA members who have offered their time and expertise in presenting the Association's viewpoint at Legislative Hearings.

Similarly, the Committee would like to acknowledge the assistance provided to us and to the Association by those MSMA members who have responded to our requests and contacted their Senators and Representatives regarding the merits or faults of certain bills.

In the weeks ahead, the General Assembly will pick up its pace and many measures which need quick action by this Association will surface. The Committee cannot stress heavily enough the importance of personal contact by MSMA members with their lawmakers. Members of the General Assembly have often commented that they receive more correspondence from members of smaller organizations than from members of the MSMA, by far the largest medical group in Missouri.

The physicians of Missouri must establish a more active relationship with their state Senators and Representatives and this Committee stands ready to offer its assistance to and to receive comments and suggestions from the membership.

JOHN I. MATTHEWS, Chairman
JAMES C. COPE
R. ALLEN CHANDLER
MAX S. FRANKLIN
ROBERT E. BREGANT

(Referred to the Reference Committee on Miscellaneous Affairs.)

REPORT OF THE COMMITTEE ON PLANNING

The work of this committee involves:

1. The formulation of long range goals
2. The specification of operational objectives
3. The anticipation of problems
4. The identification and selection of strategies
5. The adoption of appropriate policies

During the year, our Committee studied these areas and made the following recommendations:

Resolution #38—Constitutional Convention—referred to the Committee on Planning by the 1974 House of Delegates. This resolution points out that MSMA and its Council do not presently follow the current one-man, one-vote philosophy and that the MSMA should call a constitutional convention to reapportion itself.

The present study and work being done concerning the possible amalgamation of the St. Louis and St. Louis County Medical Societies were discussed.

Present MSMA Bylaws provide that "The House of Delegates shall divide the state into Councilor Districts specifying what counties each district shall include and, when the best interest of the Association and the profession will be promoted thereby, organize in each a district medical society of which all members of the component county societies shall be members." It was pointed out that the proposed amalgamation of the two St. Louis societies would cross Councilor District lines. The Committee feels that it is premature at this time to consider calling a constitutional convention. The amalgamation, if completed, would require a complete reorganization of Councilor Districts and that there is no need to consider a constitutional convention at this time because of the amalgamation situation.

Recognition Awards for Members—Staff was directed to finalize plans for recognition awards for members. Staff will select the type of award to be given (certificate, item of jewelry, etc.) and these will be presented to outgoing officers, councilors, AMA delegates, AMA alternate delegates, committee and commission members.

Change in Format for Annual Session Banquet—The Committee recommends that the Committee on Arrangements consider the feasibility of changing the format of our Annual Session. The Committee suggests that Past-Presidents and 50-Year members be honored and recognized at the Saturday General Luncheon rather than during the Annual MSMA Banquet on Saturday night.

Policy Manual—The Committee studied the draft for the new MSMA Policy Manual. They accepted the format and recommended that this be revised annually after our MSMA Annual Session. They also recommended that this be printed in a manner suitable for mailing to the individual physician rather than including it in an issue of Missouri Medicine.

Computer Services for MSMA—The Committee discussed the possibility of MSMA utilizing computer services for dues billing, dues accounting, monthly reports, membership maintenance, roster and typesetting for directories and services and recording of CME credits.

It is felt that computer services could be of great advantage for MSMA. Staff was directed to develop proposals on this service as soon as possible.

Inward and Outward WATS Line—As a benefit to members and as a possible monetary savings to the Association, the Committee discussed at length the possibility of an inward and/or outward WATS line for the Association. Staff was directed to contact the local utility to conduct a feasibility study.

Duties of Association Vice-Presidents—The officers of the Association include three Vice-Presidents. The Bylaws of the Association provide that the Vice-Presidents shall assist the President in the discharge of his duties. The Committee members felt that the present position of Association Vice-Presidents is quite possibly an honorary designation. Possibly, the Vice-Presidents should be invited to Council meetings and be utilized by the President in attending meetings as his designee and/or being assigned by the President as ex officio members of certain committees and commissions of the Association. Their responsibilities could be to stimulate, guide and maintain liaison and otherwise assist commission and committee chairmen.

Planning Committee Liaison with the President Elect—The Committee requests that the MSMA President Elect shortly after his election meet with this committee to discuss his proposed program for his year as President. Perhaps the committee can be of assistance in helping him accomplish some of his objectives.

Paul H. Rother, Chairman
Hector W. Benoit, Jr.
William D. Bradshaw
T. N. Cofer
James C. Cope
Oral B. Crawford
J. Will Fleming
James A. Hasek
David N. Kerr
Charles P. McGinty

REPORT OF THE AD HOC COMMITTEE ON MEDICAL FOUNDATIONS AND REVIEW ORGANIZATIONS

A number of the members of this Committee have been quite active in the Foundation and peer review organization functions. The most important occurrence will be part of the Annual Report of the Health Care Foundation of Missouri. As you know, the Health Care Foundation has changed its Constitution and By-Laws to allow for a restructuring of the Board of Directors. It also has accepted a contract from HEW to set up a PSRO Support Center. The Foundation-Support Center has been quite active during the past year in helping to organize the various PSRO areas that were not already organized and in helping to strengthen those which were. At present, it is helping Area IV (the Springfield area) to obtain a planning contract from HEW for PSRO activity. A sister organization, the Association of Missouri Peer Review Organizations, or AMPRO, is being formed to handle that sector of medical practice which does not come under Medicare, Medicaid or maternal and child welfare.

We have had one disappointment in that the St. Louis area, CEMPROC, has not seen fit to enter into the organization of the new Board of Directors of the Health Care Foundation-Support Center or the Board of AMPRO. We hope that they will understand what we are trying to do during the next year and agree to join with us in this common effort.

Charles P. McGinty, Chairman
Robert E. Bregant
Elbert R. Olson
Arthur A. Porporis
C. Y. Thomas

(Referred to the Reference Committee on Reports of Officers.)

REPORT OF COMMITTEE ON VOLUNTARY HEALTH AGENCIES

On Sept. 22, 1974, the Committee on Voluntary Health Agencies met with representatives from nine Missouri Voluntary Health Organizations in Jefferson City.

The following organizations were represented:

- Missouri Epilepsy Foundation
- Cystic Fibrosis National Research Foundation, Gateway Chapter
- Multiple Sclerosis Society
- American Red Cross, St. Louis Bi-State Chapter
- Muscular Dystrophy Association of America, Inc.
- The March of Dimes National Foundation, Inc.
- Missouri Public Health Association
- Missouri Heart Association

The representative for the Missouri Epilepsy Foundation also had been authorized to represent the Greater Kansas City League, Inc. (Epilepsy).

Those organizations who were not present at the 197 meeting each had the opportunity to present the purposes needs and aims of each of the organizations they represent Those organizations who were present last year and made the presentation were offered the opportunity to provide the mmittee with an update of their activities in the interim riod.

Those organizations presenting for the first time will be ked to prepare a summary of the purpose, size and type membership and current activities and submit to MSMA fice this information.

Following this, there was a discussion in which the Com-ittee and the representatives of the Voluntary Health Or-nizations participated. Overall, the recommendations were ry similar to those made last year with an expression of ppreciation for the addition of the listing of Missouri Vol-tary Health Agencies and Organizations which appeared the July 15, 1974 Director Issue of Missouri Medicine.

There was a discussion on how more information might included in the Directory Issue with the recommenda-n that the staff make a determination of the cost of put-g in the Journal the additional information in a format milar to the AMA publication on National Voluntary ealth Agencies. When this information is obtained, each those organizations which were listed in 1974, plus any lditional ones known, would be contacted by letter and uld then make the determination of their willingness to pply the funds to make such possible. The cost of this also ould include the obtaining of sufficient number of reprints r distribution to the osteopathic physicians of the state rough their organization.

Voluntary health agencies have been contacted concern-g the above proposal and we are awaiting their decision payment of costs.

Again, the Committee felt that the meeting was of suffi-ent value, that it should be continued on an annual basis.

W. C. Allen, Chairman
Melvin A. Cassel
Joseph L. Fisher
Paul S. Quinn
Carl Siegel

(Referred to Reference Committee on Medical Education d Public Welfare.)

Reports of Commissions and Ad Hoc Committees

REPORT OF THE COMMISSION ON PUBLIC AFFAIRS

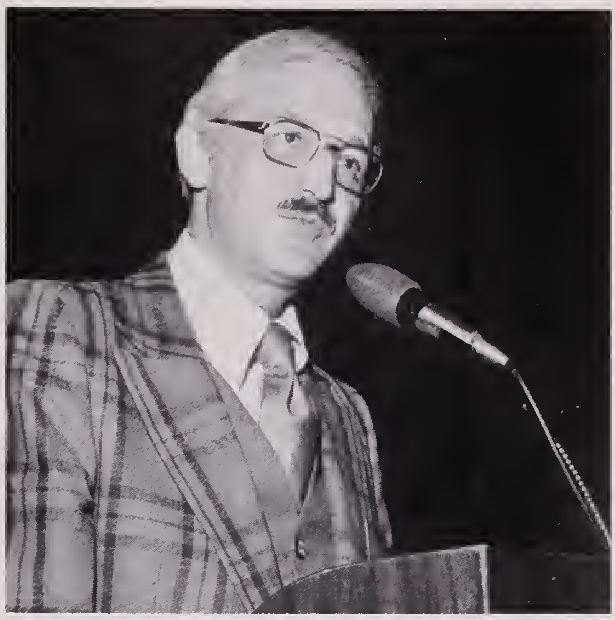
The MSMA Commission on Public Affairs met on Sept. , 1974 in Columbia and recommended several items to the ouncil.

Perhaps the most important, and disheartening, recom-endation was for the discontinuance of the Annual Public ffairs Conference. Despite excellent and informative pro-ams, attendance at the Conferences has been poor. The ommission will continue to re-evaluate this activity for fu-re years. As a replacement for the Conference, the Com-ission recommends the following:

(A) That MSMA members be encouraged to appear before local clubs and organizations to tell medicine's story.

(B) That a Speakers' Bureau be established in areas where they are not now functioning and that existing Speakers' Bureaus be stimulated to greater activity. It is important that these Bureaus identify speakers who are capable and willing to serve.

(C) That the Association continue to sponsor specialized meetings which answer specific needs of members, prospective members and the public, i.e., Management Workshops, Public Speaking Programs, etc.



President-Elect R. Allen Chandler addressed the House and commented upon matters to be considered by the Delegates.

The Commission considered the problems of physicians distribution and encourages the appropriate Association committees to provide their expertise and experience to non-Association groups which may be seeking solutions to this problem.

Regarding public communications, we discussed the highly successful TEL-MED system, but discovered that the system is designed more for a large local medical society and is not economically feasible for a statewide operation. The Jackson County Medical Society has recently instituted TEL-MED and we encourage each large society to investigate the system.

The Commission considered a presentation explaining the Missouri Division of Health's concern with the venereal disease epidemic in Missouri's metropolitan areas. Since the Division of Health expressed concern that part of the problem lies in the fact that private physicians are not reporting cases of venereal disease, we requested that an article be published in Missouri Medicine which would detail the problem and stress that confidentiality would be safeguarded when physicians report the disease.

The Commission endorsed a project for the Section of Behavioral Sciences of the Department of Community Health and Medical Practice at the University of Missouri-Columbia Medical School which would provide guidelines whereby hospitals could more effectively set up their emergency medical service in cooperation and coordination with other hospitals in the area. Our endorsement does not necessarily mean we will support the conclusions of the study.

The Commission on Public Affairs invites the inquiries and suggestions from the MSMA membership regarding matters we have discussed or will consider.

Richard P. Bowles, Chairman
Troy Morgan
R. A. Ritter, Jr.
C. Keith Whittaker
Stanley G. Hall
J. E. Block
Francis M. Corry
Donald R. Germann
James D. Grable

Joseph Kendis
Allen P. Klippel
Byron E. Watts
Hubert A. Ritter
James C. Denninghoff
Richard A. Sutter

(Referred to the Reference Committee on Miscellaneous Affairs.)

COMMISSION ON MEDICAL ECONOMICS, THIRD PARTY MEDICINE AND GOVERNMENTAL RELATIONS

(This report includes all reports of ad hoc committees set up under this Commission.)

An ad hoc committee to study and implement the resolution approved by the MSMA House of Delegates concerning the negotiation of a definite fee schedule for physicians providing care for Title XIX recipients and further negotiating a list of ancillary services that will be covered for payment by the Missouri Division of Family Services (Formerly the Division of Welfare). It was noted that a similar resolution was adopted at the annual meeting of the MAOPS. Efforts will be coordinated between the two associations.

The Committee was directed to develop a schedule that they believe will be acceptable to Missouri physicians. Also, they will need to determine if the schedule should be approved by physicians before or after consultations with the Division of Family Services. The legal implications involved in implementing this resolution were discussed at length.

The Commission endorsed the principle that under no circumstances should physicians fees be established solely on the basis of geographic location.

The ad hoc committee also was directed to obtain from State Medicaid officials a list of items, services and procedures for which providers may not be reimbursed under the Medicaid Program.

"Waiver of Liability" as outlined in Medicare Bulletin #3—This Bulletin was issued by fiscal intermediaries in April of 1974 to implement the 1972 Medicare amendments that basically provide that a beneficiary may be "held harmless" for disallowed claims when certain conditions are met. In a "hold harmless" situation, the liability would either shift to the Medicare program or to the physician depending upon whether the physician exercised due care in dealing with the beneficiary and the Medicare program. The three basic aspects of the 1972 amendments that determine whether the liability of a beneficiary will be limited or waived in Part B denial cases involving physicians services are:

1. The denial is made because services rendered after October 30, 1972 are not reasonable and necessary or constitute custodial care
2. Payment is sought by the physician through the assignment provision for reimbursement (beneficiaries would still be responsible for denied services on non-assigned claims)
3. The beneficiary did not know or could not have been expected to know that the services are not covered.

Evidently, the waiver provision applies only to services or items denied as described in the following:

> "Services or items recognized as effective in some circumstances but not considered reasonable and necessary in particular cases or for certain specified conditions."

The Commission feels that this category of non-reimbursable services is quite vague. Staff was directed to contact the fiscal intermediary and attempt to obtain a list complete with code of items and services that are considered not reimbursable and also to determine from Medicare officials what items and services are considered to be effective and what items and services are considered to be not effective If it was determined that there is a flagrant abuse of procedures considered not to be effective, the Commission would like to be aware of this in order to inform MSMA members.

Resolution #14 entitled "Involvement of Third Parties in the Practice of Medicine," adopted at the 1974 Session of the House of Delegates, was referred to this Commission by the MSMA Council. The resolved portion of this resolution states "that all persons or organizations be informed that decisions involving physician care must be discussed with the involved physicians or their representatives before such changes are made."

The Commission recommends that a letter be drafted by staff and directed to all third parties, including the Federal Government, fiscal intermediaries, insurance companies and hospitals. In this letter, they will be requested to develop mechanisms that will provide for the involvement of physicians in all decisions involving physicians care before such rulings, changes and decisions are made. They should be requested to advise MSMA of the mechanism that they have developed to implement this.

The Council had suggested that an Ad Hoc Governmental Relations Committee be appointed under the auspices of this Commission in an effort to stay abreast of rapidly changing government programs. After discussion, it was agreed that the Chairman will appoint a committee on a regional basis He will utilize the names submitted as CHP advisors to county medical societies as outlined in Resolution 20 adopted by the MSMA House of Delegates in 1974.

This Commission has attempted to obtain codes from the various carriers to enable individual physicians to determine coverage of health insurance benefits. To date, this attemp has been quite unsuccessful. Most carriers state that they have many varying group and individual contracts available and that within these many contracts there are also many different benefit levels that may be selected by the purchaser. They feel that it is impossible to generalize and code a benefit for a particular procedure without knowing the contract under which the benefit would be paid. Staff was directed to continue this effort as an ongoing project.

This Commission has worked for the development of a uniform claim form for accident and health insurance fo many years. The AMA's Council on Medical Service and it Committee on Health Care Financing has long recognized the need to simplify and standardize the reporting of physicians' services for reimbursement under the various types of government programs and third party policies. In 1973, the AMA Health Insurance Claim form was developed. Thi form is available on order from the AMA. It was pointed ou to the Commission that the Texas delegation objected to the statement on the reverse of the form. It is understood tha this is now being corrected by AMA and a new form i available. Staff was directed to obtain the new forms and send them to all members of the Commission for review Staff was further directed to obtain an opinion from lega counsel concerning this form.

The SSA states, "The proposed Health Insurance Service Report contains all the elements necessary to process a Medicare claim when the physician or supplier complete the form. We will approve the use of the form in lieu of the existing SSA-1490 when other major third party insurors i an area also are willing to use it as their claims form. We do not believe it would be wise to require the use of a new form by physicians until other insurors in an area are willing to do so." It is our understanding that if a carrier re eives a Medicare claim executed on the AMA form it will processed if it contains the information called for on the propriate SSA-1490.

The Commission recommends that an ad hoc committee appointed to develop a communications program for embers and citizens of this state concerning National ealth Insurance. Their activities would include articles for e press and other state publications, articles in MISSOURI EDICINE and a speakers bureau.

The Commission discussed the work of the Missouri State nate Committee that is conducting hearings throughout e state reviewing the Welfare Programs, including all adinistrative procedures which are followed by the Division Family Services. It was recommended by the Commison that Dr. Peterson develop testimony documenting slow yment to providers for services rendered under Medicaid d on the disparity of payment to physicians for identical ocedures and services provided under Medicaid.

The Missouri State Senate Select Committee on Welfare ade the following recommendations concerning the Medicd program:

1. A reduction in the excessive amount of paper work and forms.
2. Rapid response to all correspondence received at all levels of operation.
3. Payments to vendors within a maximum of 30-45 days.
4. Study current vendor fee schedules. In particular, consider a reasonable increase in payment for prescription service by pharmacies to be more in line with other states.
5. Review policy on requesting medical charts and proof of treatment in an effort to reduce number requested.
6. Establishment and utilization of the services of medical, dental, hospital administrators and pharmaceutical advisory committees for developing a better working relationship, updated treatment allowed and better administrative procedures.
7. Assure consistent payment allowance for same coded medical services.
8. Assurance that non-medical personnel are not making medical decisions which intimately affect the practice of medicine without the advice of the practicing physician.
9. Study the possibility of contracting with a private organization for the review of all medical claims made under Medicaid.

The Commission discussed Retail Credit Company hanling of privileged information between doctor, patient and surance company. It was pointed out that the Retail redit Company policy does not allow them to retain a py of the underwriting medical history report or any of e medical information it contains. They act simply as carers between the physician and the insurance company. heir files contain only a control sheet listing the source of formation and the date it was sent to their customer. hey have also indicated their willingness to cooperate with hysicians. They will sign an agreement with any doctor, inic or society. The agreement would place full responsiility on the Retail Credit Company for the proper handling the privileged information once it comes into their posseson. Staff was directed by the Commission to communicate ith the Retail Credit Company and to commend them for eir thoughtfulness in contacting organized medicine and plaining their procedures and to further indicate approval their handling of privileged information.

The Medical Advisory Committee to the Missouri Mediaid program will meet with officials of the Division of Famy Services on Feb. 20, 1975. Members of this Committee re Drs. Leslie F. Bond, St. Louis; James A. Campbell, Macon; Rae W. Froelich, Lebanon; Max A. Heeb, Sikeston; Stanley S. Peterson, Springfield; and John H. Wells, Kansas City.

STANLEY S. PETERSON, Chairman
E. WARREN ALLEN
CHARLES W. CHASTAIN
E. J. CUNNINGHAM, JR.
MARK D. EAGLETON
RAE W. FROELICH
JOHN A. GRIFFITH, JR.
MAX A. HEEB
KENNETH K. KEOWN
JOHN M. LAIRD
FRANCIS M. MAPLE
JOHN TORONTOW
E. E. WADLOW
HERBERT C. WIEGAND
VICTOR B. BUHLER

(Referred to the Reference Committee on Resolutions.)

REPORT OF THE MEDICAL ADVISORY COMMITTEE TO THE MISSOURI STATE MEDICAID PROGRAM

At the February 20 meeting, the three main topics discussed were: (1) Budget, (2) Claims Processing, (3) The proposed Physicians' Medical Manual.

(1) *Budget*—The request to the Legislature for the fiscal year of 1975-1976 for the Division of Family Services is $123,754,676 (an increase of $20,850,444). This budget includes hospital inpatient and outpatient care, mental hospitals, nursing homes, drugs, physicians, dental, laboratory and x-ray, ambulance, home health care, optometric, family planning. The Physicians Service portion amounts to $17,879,400 (approximately 14% of the total budget). An increase of $2,859,962. The original budget request of $131,559,568 has already been cut $7,804,892 to its present $123,754,676.

In Missouri and surrounding states that provide services to Missouri patients by their proximity, 7,226 M.D.s and 1,126 D.O.s provide care to 260,000 different persons per year. The State responsibility for the total Medicaid bill will be increased by over $1 million in July, 1975 since the federal matching will be 54% instead of 55% after July.

(2) *Claims Processing*—We can hopefully look forward to more efficient claims processing if the department is allowed to increase its computer capability after April. Some helpful input from the physician in order to expedite claims processing and ease the administrative pile-up would be to bill weekly rather than once a month or once a quarter. The physicians sending in the Medicaid bills weekly would help to reduce claims processing pile-up and smooth the process of paying claims. Currently, claims that do not have a Medicare component that are received before the 20th of one month are paid the 25th of the next month. With new computer hardware, there could be two payments a month—one on the 15th and one on the 30th—with the latter one not only picking up new claims but, also, correcting errors in the claims received on the 15th. The problem of the new Medicaid patient with a letter and no complete number was thoroughly discussed. It was pointed out that if the physician is not allowed to collect merely on the letter, that he often never sees the patient again to obtain the full number for processing the claim. It is hoped that the new system will help to rectify this.

(3) *Physicians' Medical Manual*—At the last annual meeting of the Missouri State Medical Association and the Missouri State Osteopathic Association, resolutions were passed indicating that the physicians of this state would favor the publication of a manual showing the services cov-

ered and the amount paid for each service by the Division of Family Service (Medicaid). Both organizations also passed resolutions indicating that there should be no discrimination of fees on the basis of geography alone. This information has been communicated to the Division of Family Service in the past, the main thrust being to encourage more physician participation in the program. It has been the feeling that many physicians have been discouraged from "active" participation in the program because of inconsistency of payments and retroactive denial. It also has been the opinion of most physicians who are actively involved in the program that the majority of Medicaid patients are being cared for by a minority of physicians.

In response to the desires of the Missouri State Medical Association and the Missouri State Osteopathic Association, the Division of Family Services is preparing a Physicians' Medicaid Manual which will have a list of services, procedures, as well as laboratory, x-ray and ancillary services that will be provided and a definite fee that will be paid. This of course would be as before, depending on complete funding of the program.

It is hoped that this document will help to correct many of the misunderstandings and problems of the past.

All physicians participating in the Medicaid program should get their claims in before June so that they can be processed before the reduction in the federal commitment. This will leave more dollars for the program in the state of Missouri.

It also is apparent that a favorable presentation of the fiscal needs as well as computer hardware needs of the Division of Family Service to our Legislative friends is in order.

Max A. Heeb, Chairman
Leslie F. Bond
James A. Campbell
Rae W. Froelich
Stanley S. Peterson
John H. Wells

(Referred to the Reference Committee on Resolutions.)

REPORT OF THE COMMISSION ON CONTINUING EDUCATION AND HEALTH MANPOWER

(This report includes all reports of ad hoc committees set up under this Commission.)

The Commission on Continuing Education and Health Manpower appointed three Ad Hoc Committees as follows: Ad Hoc Committee on Continuing Medical Education, Ad Hoc Committee on Health Manpower and Ad Hoc Committee—117th Annual Session. The Ad Hoc Committees implemented directives of the MSMA Council and worked closely with allied health services in the study and solution of problems referred. Specific details of Committee action can be found in the individual Ad Hoc Committee Annual Reports published herein.

The Commission worked closely with the Commission on Interspecialty Medicine in further study and planning of a new statewide program on Continuing Medical Education and in the development of Scientific Sessions for the 117th Annual Session. It is anticipated that during MSMA's 1975 Annual Session, the American Medical Association will approve the scientific portion of the program for category I Credit.

George H. Ladyman, Chairman
Andrew McCanse
A. Sherwood Baker
Richard J. Dames
John C. Soucy
Charles A. Worley
H. Peter Ekern
B. J. Bass
Paul R. Young
Lucian W. Ide
W. Thomas Morgan, Jr.
W. Wayne Boydston
Robert F. Dettmer
Robert B. Deitchman
Marvin A. Singleton

REPORT OF THE AD HOC COMMITTEE ON HEALTH MANPOWER

The Ad Hoc Committee on Health Manpower has had no formal meeting. Its only specific request has been the approval of two resolutions submitted by the registered nurses:

1. "The Registered Nurse and the Sitter."
2. "The Registered Nurse and Doctors' Phone and/or Verbal Medication Orders."

To conserve time and money, the members were polled by mail and these resolutions were approved. Attached herewith are the two resolutions.

The Ad Hoc Committee expresses appreciation to the parent Commission and the MSMA staff for their cooperation and assistance.

Charles A. Worley, Chairman
B. J. Bass
A. J. Signorelli
Richardson K. Noback
William C. Allen
Roman C. Hammes

Resolution—The Registered Nurse and the "Sitter"

PREAMBLE

A statement of policy by the professional organization or by an employing agency does not relieve the individual nurse of responsibility and accountability for his or her acts nor provide immunity from legal action if the nurse is negligent. A policy statement does give the nurse support by setting forth recommended policy which responsible professional groups consider appropriate practice and sound procedure.

Whereas, The registered professional nurse has the responsibility for the nursing care practices on a patient care unit, and

Whereas, Families are contracting with unprepared lay people to sit with a family member in the hospital, and

Whereas, These sitters are unprepared to give nursing care and are employed only to stay with patients, and

Whereas, Hospital policies may not cover the nurse's responsibility in such instances, and

Resolved, That the MoNA adopt the policy that the registered professional nurse remain fully responsible for planning, implementing and evaluating nursing care provided to patients having sitters. It is further resolved that the presence of sitters in no way abrogates the responsibility of the registered professional nurse in charge of the unit.

Be It Further Resolved, That in patient-care facilities where the sitter is utilized, a hospital policy must be written defining and regulating duties and functions of sitters and the role relationships of the nursing staff and the sitter, and the hospital inform families of this policy.

Resolution—The Registered Nurse and Doctors' Phone and/or Verbal Medication Orders

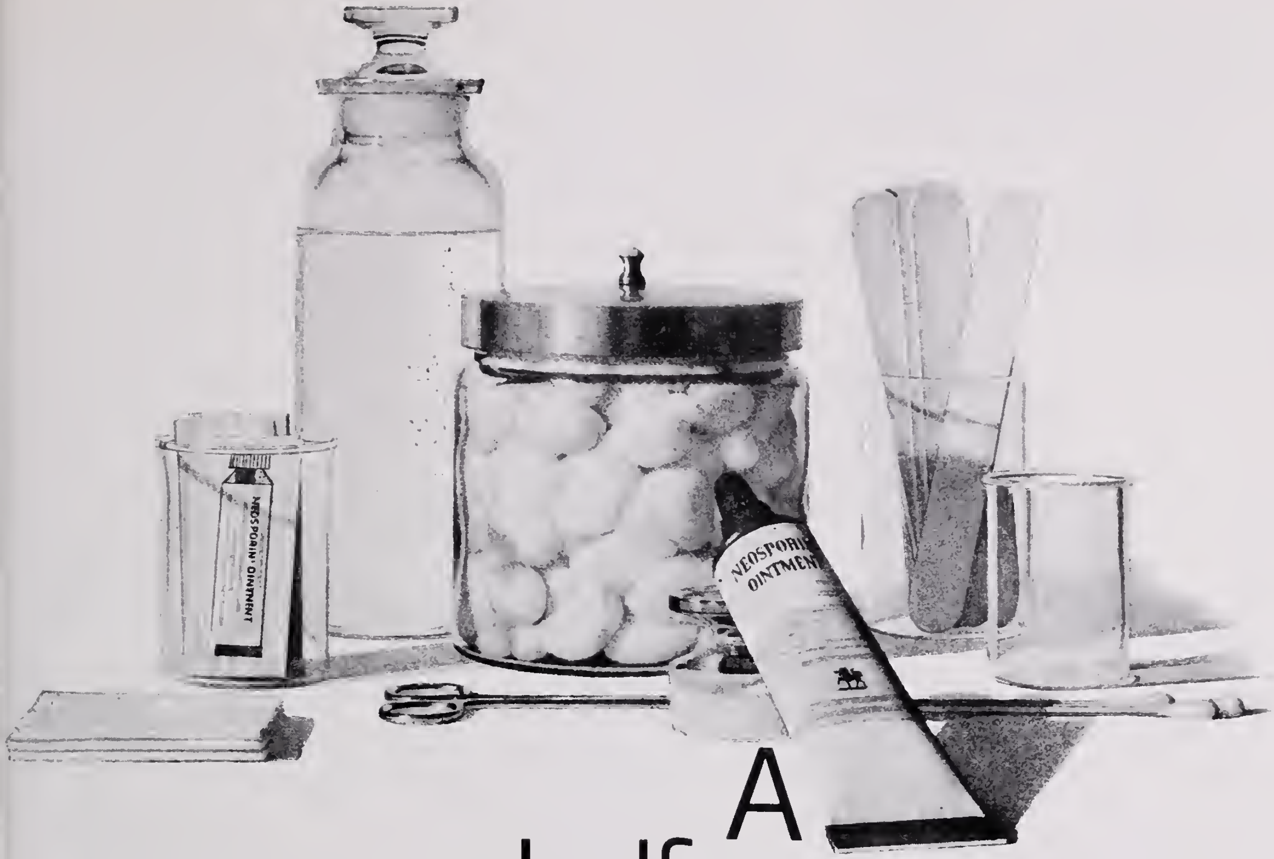
PREAMBLE

A statement of policy by the professional organization or by an employing agency does not relieve the individual nurse of responsibility and accountability for his or her own acts nor provide immunity from legal action if the nurse is negligent. A policy statemen does give the nurse support by setting forth recommended policy which responsible professional groups consider appropriate practice and sound procedure.

Whereas, A patient who requires medications requires the expertise of a physician for evaluation of his total needs, and

Whereas, Medication shall only be administered by individuals who have successfully completed an educational program designed to prepare them to competently meet therapeutically safe standards in the administration of medications, and

Whereas, medications are only administered upon the written order by the physician except in emergency situations, and



A half-ounce of prevention

Use it to prevent a topical infection. Or to treat one that's already started. In either case, it's good medicine. Whether for lacerations, burns, open wounds, IV catheter or surgical aftercare. Neosporin® Ointment provides broad antibacterial coverage against common susceptible pathogens. And since it contains three antibiotics that are rarely used systemically, the risk of sensitization is reduced. Neosporin Ointment. A half-ounce of prevention. Also available in a full ounce of prevention and in convenient foil packets.

Neosporin Ointment carried on Apollo and Skylab missions.

Neosporin® Ointment
(polymyxin B-bacitracin-neomycin)

Each gram contains: Aerosporin® brand Polymyxin B Sulfate 5,000 units; zinc bacitracin 400 units; neomycin sulfate 5 mg (equivalent to 3.5 mg neomycin base); special white petrolatum qs. In tubes of 1 oz and 1/2 oz and 1/32 oz (approx.) foil packets.

IDICATIONS: *Therapeutically,* used as an adjunct to appropriate systemic ierapy for topical infections, primary or secondary, due to susceptible organms, as in: • infected burns, skin grafts, surgical incisions, otitis externa primary pyodermas (impetigo, ecthyma, sycosis vulgaris, paronychia) • secondarily infected dermatoses (eczema, herpes, and seborrheic dermatitis) traumatic lesions, inflamed or suppurating as a result of bacterial infection. *Prophylactically,* the ointment may be used to prevent bacterial contamination burns, skin grafts, incisions, and other clean lesions. For abrasions, minor cuts d wounds accidentally incurred, its use may prevent the development of fection and permit wound healing.

NTRAINDICATIONS: Not for use in the eyes or external ear canal if the eardrum perforated. This product is contraindicated in those individuals who have own hypersensitivity to any of the components.

RNING: Because of the potential hazard of nephrotoxicity and ototoxicity e to neomycin, care should be exercised when using this product in treating tensive burns, trophic ulceration and other extensive conditions where absorption of neomycin is possible. In burns where more than 20 percent of the body surface is affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended.

PRECAUTIONS: As with other antibacterial preparations, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

ADVERSE REACTIONS: Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section).

Complete literature available on request from Professional Services Dept. PML.

Wellcome
Burroughs Wellcome Co.
Research Triangle Park
North Carolina 27709

DYAZIDE®

Each capsule contains 50 mg.
of Dyrenium® (brand of triamterene)
and 25 mg. of hydrochlorothiazide.

makes sense

For long-term control of hypertension*

Before prescribing, see complete prescribing information in SK&F literature or *PDR*. The following is a brief summary.

* WARNING
This fixed combination drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual patient. If the fixed combination represents the dosage so determined, its use may be more convenient in patient management. The treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

Indications: *Edema:* That associated with congestive heart failure, cirrhosis of the liver, the nephrotic syndrome; steroid-induced and idiopathic edema; edema resistant to other diuretic therapy. *Mild to moderate hypertension:* Usefulness of the triamterene component is limited to its potassium-sparing effect.

Contraindications: Pre-existing elevated serum potassium. Hypersensitivity to either component. Continued use in progressive renal or hepatic dysfunction or developing hyperkalemia.

Warnings: **Do not use dietary potassium supplements or potassium salts unless hypokalemia develops or dietary potassium intake is markedly impaired.** Enteric-coated potassium salts may cause small bowel stenosis with or without ulceration. Hyperkalemia (>5.4 mEq/L) has been reported in 4% of patients under 60 years, in 12% of patients over 60 years, and in less than 8% of patients overall. Rarely, cases have been associated with cardiac irregularities. Accordingly, check serum potassium during therapy, particularly in patients with suspected or confirmed renal insufficiency (e.g., elderly or diabetics). If hyperkalemia develops, substitute a thiazide alone. If spironolactone is used concomitantly with 'Dyazide', check serum potassium frequently—both can cause potassium retention and sometimes hyperkalemia. Two deaths have been reported in patients on such combined therapy (in one, recommended dosage was exceeded; in the other, serum electrolytes were not properly monitored). Observe patients on 'Dyazide' regularly for possible blood dyscrasias, liver damage or other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving Dyrenium (triamterene, SK&F). Rarely, leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with the thiazides. Watch for signs of impending coma in acutely ill cirrhotics. Thiazides are reported to cross the placental barrier and appear in breast milk. This may result in fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly other adverse reactions that have occurred in the adult. When used during pregnancy or in women who might bear children, weigh potential benefits against possible hazards to fetus.

Precautions: Do periodic serum electrolyte and BUN determinations. Do periodic hematologic studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in postsympathectomy patients. The following may occur: hyperuricemia and gout, reversible nitrogen retention, decreasing alkali reserve with possible metabolic acidosis, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), digitalis intoxication (in hypokalemia). Use cautiously in surgical patients. Concomitant use with antihypertensive agents may result in an additive hypotensive effect. 'Dyazide' interferes with fluorescent measurement of quinidine.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis; rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting (may indicate electrolyte imbalance), diarrhea, constipation, other gastrointestinal disturbances. Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and, rarely, allergic pneumonitis have occurred with thiazides alone.

Supplied: Bottles of 100 capsules; in Single Unit Packages of 100 (intended for institutional use only).

SK&F Co., Carolina, P.R. 00630
Subsidiary of SmithKline Corporation

'DYAZIDE'

Just once or twice daily for maintenance. Hydrochlorothiazide to help keep blood pressure down and triamterene to help keep potassium levels up.

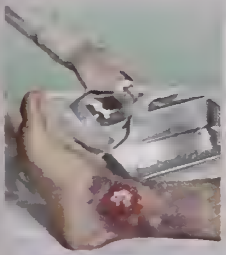
adjunctive therapy for wound debridement

HELPS TO REMOVE:

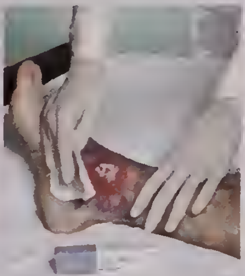
- Necrotic Tissue and Associated Odor

HELPS PREPARE WOUND FOR:

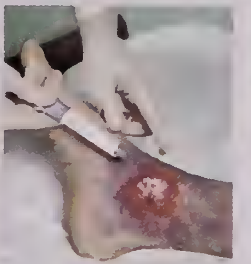
- Granulation/Healing
- Granulation/Grafting



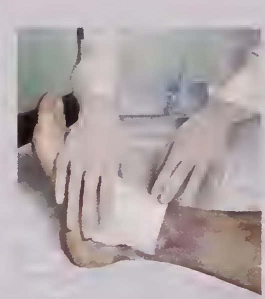
CLEANSE WOUND
Thoroughly cleanse and irrigate wound area with sodium chloride or water solutions. Wound MUST be cleansed of antiseptics or heavy-metal antibacterials.



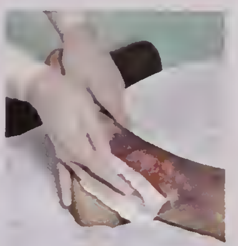
THOROUGHLY MOISTEN
Thoroughly moisten wound area either through tubbing, showering, or wet soaks (e.g., sodium chloride or water solutions).



APPLY ENZYME
Apply a layer of TRAVASE Ointment. Assure intimate contact with necrotic tissue and complete wound coverage.



APPLY MOIST DRESSING
Apply loose moist dressings (most important with dry leathery eschar).



CHANGE DRESSINGS
When changing dressing, gently wipe away the dissolved material. Repeat the procedure, including application of TRAVASE Ointment, 3 to 4 times per day for best results.

Travase® Ointment
brand of Sutilains

Travase® Ointment
brand of Sutilains
FLINT
Each gram contains 82,000 units of sutilains in a hydrophobic ointment base (95% white petrolatum
REFRIGERATE

Travase® Ointment
brand of **Sutilains**

Description
TRAVASE® (brand of sutilains) Ointment is a sterile preparation of proteolytic enzymes, elaborated by Bacillus subtilis, in a hydrophobic ointment base consisting of 95 % white petrol... polyethylene. One gram of ointment ... casein units of protec...

...impair ... wound healing (4). ...temperatures these proteolytic enzymes have optimal ...tivity in the pH range from 6.0 to 6.8

Indications
For wound debridement (1,2)—TRAVASE Ointment is indicated as an adjunct to established methods of wound care for biochemical debridement of the following lesions:

Second and third degree burns.
Decubitus ulcers.
Incisional, traumatic, and pyogenic wounds.
Ulcers secondary to peripheral vascular disease.

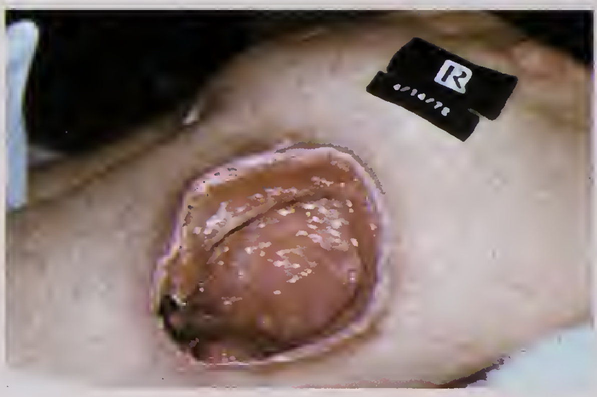
FLINT LABORATORIES
DIVISION OF TRAVENOL LABORATORIES, INC
Deerfield, Illinois 60015

Please see next page for prescribing information.

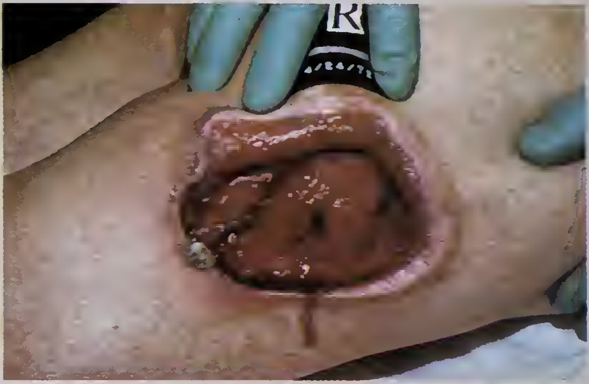
Travase® Ointment brand of Sutilains

ulcers

TERRY V. CARLE, M.D., CLINICAL INSTRUCTOR, DEPT. OF PHYS. MED. & REHAB.,
CRAIG REHABILITATION HOSPITAL, UNIVERSITY OF COLORADO



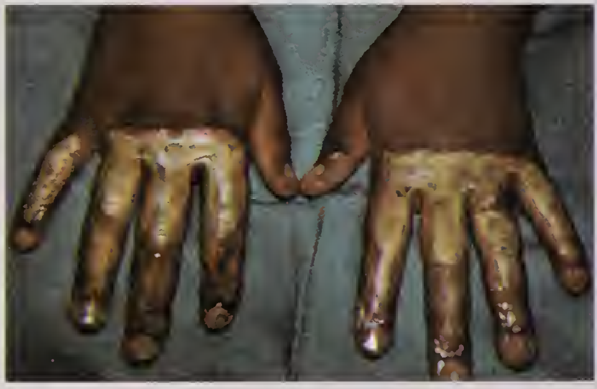
Before treatment, necrotic matter coated the inner surfaces of this decubitus ulcer.



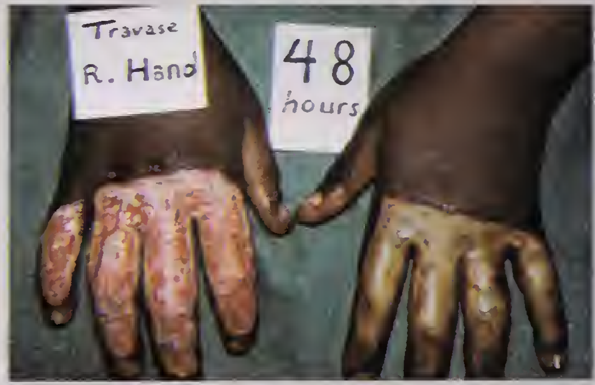
After nine days of TRAVASE therapy, debridement is nearly complete and granulation evident.

burns

DALE B. DUBIN, M.D., DIPLOMATE,
AMERICAN BOARD OF PLASTIC SURGERY, TAMPA, FLORIDA



Before treatment . . .



48 hours following treatment with TRAVASE Ointment on right hand; left hand is control.

Travase® Ointment

(brand of Sutilains)

Indications: For wound debridement, TRAVASE Ointment is indicated as an adjunct to established methods of wound care for biochemical debridement of the following lesions:

- Second and third degree burns,
- Decubitus ulcers,
- Incisional, traumatic, and pyogenic wounds,
- Ulcers secondary to peripheral vascular disease.

Contraindications: Application of TRAVASE Ointment is contraindicated in the following conditions:

- Wounds communicating with major body cavities,
- Wounds containing exposed major nerves or nervous tissue,
- Fungating neoplastic ulcers,
- Wounds in women of child-bearing potential—because of lack of laboratory evidence of effects of TRAVASE upon the developing fetus.

Warning: Do not permit TRAVASE Ointment to come into contact with the eyes. If contact is made, immediately rinse with copious amounts of water, preferably sterile.

Precautions: A moist environment is essential to optimal activity of the enzyme. Enzyme activity may also be impaired by certain agents (see package insert). Although there have been no reports of systemic allergic reaction in humans, studies have shown that there may be an antibody response in humans to absorbed enzyme material.

Adverse Reactions: Consist of mild, transient pain, paresthesias, bleeding and transient dermatitis. Pain usually can be controlled by administration of mild analgesics. Side effects severe enough to warrant discontinuation of therapy occasionally have occurred.

If bleeding or dermatitis occurs as a result of the application of TRAVASE Ointment, therapy should be discontinued. No systemic toxicity has been observed as a result of the topical application of TRAVASE Ointment.

DOSAGE AND ADMINISTRATION: STRICT ADHERENCE TO THE FOLLOWING IS REQUIRED FOR EFFECTIVE RESULTS OF TREATMENT:

1. Thoroughly cleanse and irrigate wound area with sodium chloride or water solutions. Wound MUST be cleansed of antiseptics or heavy-metal antibacterials which may denature enzyme or alter substrate characteristics (e.g., hexachlorophene, silver nitrate, benzalkonium chloride, nitrofurazone, etc.).
2. Thoroughly moisten wound area either through tubbing, showering, or wet soaks (e.g. sodium chloride or water solutions).
3. Apply TRAVASE Ointment in a thin layer assuring intimate contact with necrotic tissue and complete wound coverage extending ¼ to ½ inch beyond the area to be debrided.
4. Apply loose wet dressings.
5. Repeat entire procedure 3 to 4 times per day for best results.

FLINT LABORATORIES
DIVISION OF TRAVENOL LABORATORIES, INC
Deerfield, Illinois 60015

WHEREAS, The use of verbal or phone orders increases the possi- ity of error or misunderstanding of name of patient to receive dication, name of drug, dosage of drug, frequency of administra- n and method of administration, and

WHEREAS, Only registered professional nurses, or licensed prac- al nurses who have successfully completed a prescribed medica- n course are held accountable for safe practice in the administra- n of medication.

Resolved, That the Missouri Nurses' Association, Missouri State sociation of LPNs, Missouri Hospital Association, Missouri State dical Association, Missouri Nursing Home Association, Missouri armaceutical Association, Missouri Osteopathic Association of ysicians and Surgeons and Missouri Dental Association adopt the lowing statements:

1. All health care agencies should have written medication policies and procedures and established standards for the administration of medication.
2. All Registered Nurses and Licensed Practical Nurses should meet the level of competency required by established standards for the administration of medication before being assigned to the administration of medications.
3. An Educational program in the administration of medications should be provided those registered nurses and licensed practical nurses who do not meet the defined standards for the administration of medications before they are assigned to administration of medications.
4. Only Registered Nurses and Licensed Practical Nurses who have demonstrated their competency in the administration of medications may receive verbal and/or phone orders from the physician.
5. All emergency verbal and phone orders must be signed by a physician who gave the order as soon as possible and in no case longer than 24 hours after such orders.

AD HOC COMMITTEE ON CONTINUING MEDICAL EDUCATION

Following the annual meeting of the Missouri State Med- al Association in 1974, the Ad Hoc Committee was given e charge by the Council to develop a plan to institute ac- editation of hospitals and other organizations and agencies r continuing education of physicians within the state of issouri. This committee met in May and has expended ost of its efforts during the year on that project. A plan r accrediting educational institutions within the state of issouri has been developed and submitted to the Council Education of the American Medical Association. This an was reviewed by the Ad Hoc Committee and the Com- ission on Continuing Education and Manpower and by the uncil of the Missouri State Medical Association. It is an- ipated that the Council on Medical Education will ap- ove the plan prior to the annual meeting of the Missouri ate Medical Association in 1975.

It should be noted that the organizational structure and e process which was previously developed by the Ad Hoc mmittee is in place and that this original plan is designed fit into the accreditation plan proposed. It is anticipated at these plans can be implemented simultaneously in such way that there is a process for the identification of educa- nal needs, the identification of educational resources, the counting of the time spent by members of the society in ntinuing education and the accreditation of programs pre- nted by various institutions, groups and agencies within e state. All of this put together would seem to amount to voluntary continuing education program for the member- ip of the Missouri State Medical Association. It is the feel- g of the Ad Hoc Committee that the planning process is mplete and that implementation of the program can be rried out during the 1975-1976 year.

Copies of this document are available upon request from ur MSMA Headquarters Office.

PAUL R. YOUNG, Chairman
GEORGE H. LADYMAN
A. SHERWOOD BAKER
W. WAYNE BOYDSTON
THOMAS J. MITCHELL
ARNOLD BLOCK
MARVIN A. SINGLETON

REPORT OF THE AD HOC COMMITTEE 117th ANNUAL SESSION

For the fourth year in succession, the Committee invited the respective medical specialties to sponsor and develop Scientific Sessions of their own choosing to be included in the MSMA 117th Annual Session on April 17-20, 1975. The Committee is pleased to report the response was very gratifying and as a result attendance has increased. A total of twenty-four 90-minute sessions were developed and will be presented, including one General Session and two programs presented by voluntary agencies.

The Program Committee invited the medical specialties to also schedule their business and social functions during the MSMA Annual Session. Again, the response was good.

The Committee would like to express appreciation to the official representatives serving on the MSMA Commission on Interspecialty Medicine for their cooperation and interest.

GEORGE H. LADYMAN, Chairman
ANDREW MCCANSE
RICHARD J. DAMES
WILLIAM C. ALLEN
W. WAYNE BOYDSTON
PAUL R. YOUNG
W. THOMAS MORGAN, JR.
JOHN M. LAIRD, JR.

(Referred to the Reference Committee on Medical Education and Public Welfare.)

REPORT OF THE COMMISSION ON MEDICAL-LEGAL AFFAIRS

(This includes all reports of ad hoc committees set up under this Commission.)

Our Commission, along with similar committees from the Missouri Association of Osteopathic Physicians and Surgeons and the Missouri Bar Association, is recommending that MSMA consider establishing a statewide pre-trial screening panel for professional liability suits brought against physicians. To acquaint you with this system, the following are the highlights of the impartial medical-legal review plan now functioning in Jackson County:

1. Review panels will be composed of nine members, including four physicians and four attorneys. The ninth panelist will alternate between the medical and legal professions from case to case and will serve as Chairman.
2. Two alternates from each profession will be present at the beginning of any hearing and will be available to serve if needed.
3. Panel members and alternates will be selected by their respective professional associations from a pool of practitioners who have indicated in advance their willingness to serve. (It is recommended that panelists and alternates be selected by some type of random selection.)
4. Names of panelists and alternates will not be publicized prior to the hearing.
5. Each party to the review may exercise up to two challenges and request that the challenged panelists be replaced by alternates.
6. All members of a panel, including the Chairman, will be required to vote on all matters being decided by the panel, and a simple majority will constitute formal action. The panel will announce only the result of the vote without giving the actual count.
7. Request for review of a case must be filed in writing

and signed by the attorney and his client who are making the request. Requests must be accompanied by (a) an executed "release of confidential information" form; (b) a summary of the case to be presented; (c) a list of all documents which are to be introduced; (d) one copy of all such documents; and (e) a list of all attorneys and physicians, other than the ones immediately involved and/or named, who have been consulted by the complainant in connection with the alleged negligence or in treating the condition involved.

8. Any case involving an alleged act of negligence in Jackson County, Missouri will be accepted for review regardless of whether the named physician (M.D. or D.O.) is a member of the county medical or osteopathic organization. Any case involving an alleged act of negligence outside of Jackson County, Missouri will be accepted for review if the named physician (M.D. or D.O.) is a full voting member of a county medical or osteopathic organization which has formally approved the Impartial Medical-Legal Review Plan.
9. Procedural guidelines relative to hearings will be developed and made available to all persons appearing before a panel. However, the guidelines shall not restrict plaintiff's attorney from making his presentation in the manner of his own choosing.
10. At least two weeks notice shall be given prior to any hearing.
11. In a hearing both sides may use witnesses, both sides will have the right to cross-examine witnesses, members of the panel may interrogate witnesses and the panel may utilize other medical specialists as witness-consultants.
12. The medical and osteopathic organizations will use their "good offices" to obtain any physicians' office records which a panel believes would be of value in arriving at a decision.
13. The hearing and deliberations of any panel shall be considered privileged. The permanent record shall be limited to names of the principal's, a summary of the allegation, date of the hearing and the panel's finding.
14. If a panel finds there appears to be "no cause" for legal action, the attorney who has presented the case will be bound to withdraw. His client retains the right to pursue the case through new legal counsel.
15. If a panel finds there appears to be "cause" for legal action, the medical-osteopathic organizations will be bound to provide plaintiff's attorney with the names of three physicians who would be acceptable professionally as expert witnesses and who are in accord with the panel's findings. If plaintiff's attorney is unable to find a satisfactory witness from the first list, the associations will provide three more names, etc. The physician selected by the plaintiff's attorney will be formally requested by his medical or osteopathic society to make himself available to testify.

Most of the work of this Commission this past year has been handled by an Ad Hoc Committee to Develop a Professional Liability Insurance Group Plan for MSMA members (see attached Ad Hoc Committee Report). The professional liability insurance problem in Missouri is acute. We do hope to have a group plan available for our members by the time of our Annual Session.

We are encouraged by the appointment by Senator William Cason, the President Pro-Tem of the Missouri State Senate, of a six-member select committee to study professional liability insurance and malpractice problems in Mi
souri and to recommend needed legislation to the Gener
Assembly.

Irving H. Clark, Chairma
Joseph S. Cope
Vicente D. Deles
Bernard Draper
Lee T. Ford, Jr.
Frederick J. McCoy
Wilbur P. McDonald
David W. Brown
William R. McPhee
Francis X. Paletta
Harold B. Rapp
Jerome I. Simon
Robert V. Tompson
Robert L. Willcoxon
George P. Wilson

REPORT OF THE AD HOC COMMITTEE ON GROUP PROFESSIONAL LIABILITY INSURANCE

Resolution #22, adopted by the House of Delegates
1974, requested that a malpractice insurance program
developed for members as soon as possible.

After interviewing representatives of insurance firms fro
both Kansas City and St. Louis and other parts of the stat
who were interested in providing insurance on a statewi
basis, the plan which interested us most, after the evaluati
and study of all, was one which would enable the MSM
to evolve a program of professional liability insurance f
member physicians which met several criteria which we ha
established early in our deliberations. First, it involved t
formation of a corporation to be known as the Missouri Sta
Medical Insurance Plan, which should be recognized
Missouri State Laws governing insurance sales, that wou
be administered first of all by the Missouri State Medical A
sociation, with the expertise of management to be provid
by this particular firm. Arrangements were to be made
serve other members of the state by means of wide-area tel
phone service. The administration of the plan should inclu
the promotion of sales of insurance to the membership, t
receipt of applications for insurance and necessary proces
ing thereof, the binding of insurance for eligible membe
consistent with such binding authority as is afforded by t
insurance carrier to that company, the delivery of issu
policies along with invoices for the premiums, the collecti
of the premium from the individual insureds, the assistan
in the procurement of financing of premiums for individu
physicians as may be requested, the routine service of p
icy changes such as cancellations, endorsements, claim
ports from the physicians, and routine service for the in
vidual physician in all matters relating to the insurance p
icy, the underwriting of the program to be delegated by t
insurance company, assistance in the coordination of acti
ities of the Plan, issuance of policies and endorsement ther
to with copies to MSMA to the extent desired by its staff, t
preparation of accounting records for the insurance compa
with copies to MSMA to the extent desired by its staff, t
handling of all insurance company-agency relations pertai
ing to the program, the preparation and maintenance of
statistical records with copies of such records to MSMA, t
receipt and disbursement of commissions from the insuran
company the provision of advisory service to MSMA to t
extent requested and the general supervision of the Plan
satisfy the requirements of the insurance company.

Needless to say, the previously mentioned responsibiliti
are those pertaining to the insurance company as a spo
sored company with the insurance broker as an active pa
ticipant. MSMA would promote new membership and be

nsible for the performance of liaison services between its mbers, the plan and the broker, the maintenance of rec- s as required by the plan, the establishment and main- ance of professional liability education program for all mbers of the association, for it is clear that herein lies the l cure to malpractice litigation problems.

ISMA must also, as part of its obligation, in addition to ication for its members, provide a claims review, using ependent legal counsel, the cost to be borne by the insur- e company, and medical consultant service as deemed essary to properly serve the individual policyholder and professional review of the program.

The agreement worked out provides that this agreement uld remain in effect until it is cancelled, and further t the agreement could be cancelled by either member h six months notice prior to January 1 of any calendar r. Now this does not mean that the insurance is can- led. It merely makes it possible for MSMA, if dissatisfied, obtain another administrator or for the administrator to ify us that they desire that we obtain a replacement for m in management of the company. The broker who has anced this program agrees to join with MSMA in the nt formation of such a corporation and to be responsible the services described herein under the agreement sub- ted on a percentage distribution of stock or on a program erein they would be hired as the administrators of the gram for a specified fee. For those of you who are ac- inted with the Florida Medical Association program, this ery similar to their program which calls for a 51% owner- p by the Florida Medical Association and 49% by the ker involved.

The research for this program was done by Mr. James milton, Vice-President of Rollins Burdick Hunter Com- y. Rollins Burdick Hunter is the fourth largest insurance ker in North America and is a multi-national company. as a top rating with investment bankers; they are profes- nal buyers and managers of insurance.

Articles of Incorporation for MSMI, Inc. have now been d in the office of the Missouri Secretary of State. Fifty cent of the stock of this for-profit corporation will be held MSMA and 50% will be owned by Rollins Burdick Hunt- Inc. Ongoing meetings are being held to develop this poration, elect officers and directors and formally orga- e it.

Early in March, we believe that a carrier will be selected nderwrite the program.

Hopefully, by the time you are studying this report during annual meeting, a general announcement of a profes- nal liability group plan for all of our MSMA members l be made and all necessary information will be available.

IRVING H. CLARK, Chairman
R. ALLEN CHANDLER
HOWARD J. MCALHANY
JEROME I. SIMON
ROBERT L. WILLCOXON

(Referred to the Reference Committee on Constitution l Bylaws.)

REPORT OF THE COMMISSION ON INTERSPECIALTY MEDICINE

During the preceding year, the Commission Chairman has ended meetings of the Ad Hoc Committee on Continuing dical Education and kept Commission members apprised these activities. Specialty representatives have referred their respective organizations for advice as to their will- ness to participate in formulating Specialty Continuing dical Education Programs for MSMA. Affirmative re- nses to date were received from the following special- :

Allergy, Anesthesiology, Dermatology, Internal Medicine, Neurological Surgeons, Obstetrics-Gynecology, Otolaryngology, Pathology, Pediatrics, Radiology, Surgery, Urology.

Medical specialites have been polled for their sponsorship of one or more sessions at the 1975 State Meeting. The following specialty groups are sponsoring at least one 90-minute and some as many as four 90-minute sessions at the 117th Annual MSMA Session, 1975:

Allergy, Dermatology, Internal Medicine, Obstetrics-Gynecology, Ophthalmology, Otolaryngology, St. Louis Neurological Sciences, Pathology, Pediatrics, Physical Medicine and Rehabilitation, Psychiatry, Radiology, Surgery, Thoracic.

CYRIL COSTELLO, Chairman
HERBERT E. ROSENBAUM
ANWAR SHAH
WILLIAM H. AMES
FRANCIS X. LIEB
HOWARD J. MCALHANY
CLARENCE COHRS
GORDON C. SAUER
GEORGE A. JOHNSON
CHARLES A. MOLDEN
WILLIAM F. MCGINNIS
G. LYNN KRAUSE
FORREST H. KENDALL
HENRY C. ALLEN
ROBERT D. BROOKES
TOM W. STAPLE
KARL J. KURTZ
PETER W. KINSELLA
ROBERT W. ALLEN

(Referred to the Reference Committee on Medical Education and Public Welfare.)

THE COUNCIL

The Speaker stated that the portions of the reports of Council Meetings which are referred to Reference Committees are preceded by a black square (■) and are concluded with the committee assignment, which is set in bold face type.

Meeting of April 7, 1974

■ James C. Cope, M.D., Columbia, President, called the meeting to order. Those present were Drs. Cope; R. Allen Chandler, Kansas City; John I. Matthews, Jefferson City; Donald R. Judd, St. Louis; E. A. Stricker, St. James; Walter T. Gunn, St. Louis; R. A. Slickman, Kansas City; John N. Martin, St. Joseph; Max S. Franklin, St. Louis; Louis P. Hetlage, Troy; Robert Bregant, Jefferson City; Andrew McCanse, Kansas City; Howard J. McAlhany, Springfield; Claude Cooper, Thayer; E. T. Hansbrough, Poplar Bluff; Joseph V. Finnegan, St. Louis; William C. Allen and William D. Mayer, Columbia; Richardson K. Noback, Kansas City; J. Loren Washburn, Versailles; Hubert A. Ritter, St. Louis; Messrs. Allen D. Smith, Kansas City; Roger Weis, Kansas City; Hollister S. Smith, St. Louis; Lee Mortenson, Chicago; Ray McIntyre, Royal O. Cooper, Cork Swarens and Ron Ellison, Staff.

President Cope opened the meeting and introduced the new Councilor from the 7th District, Dr. Andrew McCanse of Kansas City.

Dr. Max S. Franklin was elected Chairman of the Council by acclamation and, thereby, became the presiding officer.

Dr. Howard J. McAlhany was elected Vice-Chairman of the Council, Dr. Donald R. Judd was elected Treasurer and Dr. John I. Matthews was elected Secretary.

FINANCE COMMITTEE

Dr. Franklin made the following appointments to the Finance and Budget Committee for 1974-75: Drs. Judd, Chairman; Cope, Chandler, Franklin, McAlhany, Hetlage and Martin.

NEXT COUNCIL MEETING

The next meeting of the Council will be held on Friday night, May 24 and Saturday, May 25 at the Downtown Holiday Inn, Jefferson City.

Dr. Gunn thanked the Councilors, Officers and staff for their cooperation and for the privilege of working with them during his tenure in the various offices.

President Cope indicated that the Health Care Foundation of Missouri has applied to HEW to become a statwide PSRO support center and would like MSMA endorsement. He stated that he would write such a letter of endorsement to HCFM.

LEGISLATIVE LIAISON COMMITTEE

Dr. Cope named the following to the Legislative Liaison Committee to work with the state administration on various health and medical related issues: Drs. Cope, Chairman; Bregant and Matthews.

Dr. William D. Mayer presented information regarding public information tapes which the University of Missouri is contemplating using on various radio stations in the state. These are five-minute tapes which would inform the public on various health matters. Dr. Mayer asked for Council endorsement of such a project.

It was suggested that, perhaps, the tapes would be more meaningful in a given area, if a local physician gave a brief introduction to them. It was pointed out that most radio stations would be glad to do this.

On motion of Dr. Hetlage, duly seconded, it was agreed that the MSMA cooperate with the University of Missouri in its request for endorsement of this project, noting the suggestions made by the Council regarding local physician introduction.

Mr. McIntyre reported that he had received a letter from Robert Enlow of the AMA Circulation and Records Department regarding our possible cooperation in a fund-raising project for AMA-ERF. It was pointed out in the letter that the AMA would develop a "personalized" letter and circular which could be sent to each physician over the signature of the President of the Association, Dean of the Medical School, etc. to influence the physicians to give an additional special contribution to AMA-ERF for their choice of one of the AMA-ERF projects.

It was moved, seconded and carried that the MSMA accept the proposal of the AMA and that the President of the MSMA send a letter to the membership and that AMA be notified accordingly.

Dr. Franklin indicated that the Ad Hoc Committee on Family Planning, chaired by Dr. Hetlage, would be continued for the year 1974-1975.

Dr. Hetlage discussed the Ad Hoc Committee on Governmental Relations which is to be under the auspices of the Commission on Medical Economics. It was pointed out that the Chairman of the Commission should appoint this ad hoc committee.

PUBLICATIONS COMMITTEE

Dr. Joseph Finnegan reported that the Publications Committee held a meeting on Saturday, April 6. It was indicated that in the past, osteopathic members of MSMA have been designated in the roster issue as D.O.s without a designation for M.D. members. A complaint was receiv regarding this practice. However, the Committee felt it ne essary that some designation be made and recommend that the present practice be continued.

On motion, duly seconded and carried, it was agreed accept the recommendation of the Committee regardi D.O. designation in the roster issue of Missouri Medicine.

Dr. Finnegan reported that time was spent by the Pub cations Committee discussing the decrease in advertising the Journal and, at the same time, the increase in printi costs. The Committee did not arrive at any definite soluti to the problem. Some of the suggestions were that we plore the possibility of combining our Journal with seve of those from surrounding states. Different sources of a vertising might also be tapped. It was suggested that if in vidual Councilors and Officers have suggestions regardi various advertising sources, please notify the MSMA Offi as a letter has already been prepated that can be sent them.

EDITORIAL BOARD

Dr. Finnegan suggested that a supplementary appoi ment be made to the Editorial Board; Dr. Mary B. Am St. Joseph. On motion, duly seconded, Dr. Ames was a pointed to the Editorial Board.—**Referred to Referen Committee on Reports of Officers.**

UNIFIED MEMBERSHIP WITH AMA

■ Dr. Slickman reminded the Council that the resolution lating to Unified Membership with AMA, which had be introduced into the House of Delegates, was passed as f lows:

Resolved, That changes in the Constitution and Byla of the MSMA be considered to the effect that all memb of the Association shall also be members of the AMA a be it further

Resolved, That the Council of the MSMA be instruc to assure that full and ample discussion of this import issue occur in each of the Councilor Districts and each the county societies to the end that this Resolution in a f mal manner be brought before the House of Delegates the first session of the 1975 Annual Meeting of this Assoc tion.

Dr. Slickman pointed out that since this calls for a co stitutional change, this must be brought to the attention the entire membership at least twice within the next ye Mr. McIntyre stated that in addition to publishing this the membership, it also could be sent to each society pr dent for discussion at various county medical society me ings. It was pointed out that the standing Committee Constitution and Bylaws will need to make specific word recommendations for changes in the Constitution and laws to provide for unified membership with the AMA action of the House of Delegates at the 1975 Annual S sion.

The meeting was adjourned.—**Referred to Reference C mittee on Constitution and Bylaws.**

Meeting of May 25, 1974

■ Howard J. McAlhany, M.D., Springfield, Vice-Chairm called the meeting to order. Those present were Drs. Alhany; James C. Cope, Columbia; R. Allen Chand Kansas City; John I. Matthews, Jefferson City; E. Stricker, St. James; Robert A. Slickman, Kansas City; J N. Martin, St. Joseph; Louis P. Hetlage, Troy; Robert Bregant, Jefferson City; William D. Bradshaw, Clint; Andrew McCanse, Kansas City; Claude W. Cooper, Thay; Eugene T. Hansbrough, Poplar Bluff; William D. Ma

The Annual President's Banquet

The Annual President's Banquet was an exciting highlight of the 117th Annual Session. *(Left)* Retiring President James C. Cope presents the historical MSMA presidential gavel to President R. Allen Chandler. *(Right)* Dr. Chandler in turn, presents the MSMA plaque of appreciation to Dr. Cope for his dedication and accomplishments in 1974-1975.

(Left to right) MSMA President-Elect Max S. Franklin, Irs. Walter T. Gunn, Dr. Gunn and Mrs. Franklin, all of St. ouis. Dr. Gunn is a Past-President of the MSMA.

(Left to right) Mrs. James Hughes, MSMA Secretary John I. Matthews and Mrs. Matthews of Jefferson City and Mr. James B. Hughes, President of St. Louis Blue Shield.

(Left to right) Dr. Andrew McCanse, Seventh District Councilor and Mrs. McCanse of Kansas City with Mr. Edward M. Hirsch of St. Joseph, executive secretary of the Buchanan County Medical Society; Mrs. William R. McPhee, President of the MSMA Woman's Auxiliary and Dr. McPhee of Kansas City; MSMA Past-President Joseph L. Fisher and Mrs. Fisher of St. Joseph.

and William C. Allen, Columbia; J. Loren Washburn, Versailles; Hubert A. Ritter, St. Louis; William Stoneman, III, St. Louis; Samuel B. Guze, St. Louis; Herbert R. Domke, Jefferson City; Mrs. George Lytton, Kansas City; Messrs. Sam Wheeler, Kansas City; E. Mark Halvorson, Jefferson City; Allen D. Smith, Kansas City; Hollister S. Smith, St. Louis; Ray McIntyre, Royal O. Cooper, C. C. Swarens, Ron Ellison, Staff.

Dr. Howard McAlhany, Vice-Chairman of the Council, opened the meeting stating regretfully that Dr. Max Franklin, Chairman, was ill and would not be in attendance at this meeting.

On motion, duly seconded, the minutes of the April 7, 1974 Council Meeting were approved as distributed.

REPORT OF THE EXECUTIVE SECRETARY

Mr. McIntyre reported on the attendance at the recent 116th MSMA Annual Session, indicating that 670 physicians were in attendance and total registration was 1,054. The scientific sessions were well attended. He read several letters from 50-year-member physicians which indicated that the 50-year pins are definitely appreciated.—**Referred to Reference Committee on Reports of Officers.**

■ Mr. Ron Ellison stated that a meeting will be held on June 8 by the Commission on Interspecialty Medicine, the Commission on Continuing Education and Health Manpower, the Ad Hoc Committee for the 117th Annual Session and the Councilor District Directors on CME. This meeting will be held to discuss and develop guidelines for CME for the state of Missouri and to begin plans for the 117th Annual Session.

Dr. Hansbrough stated that there are many ongoing CME programs in the state and he felt that the Ad Hoc Committee on CME should be given the authority to examine and approve these programs. After brief discussion, it was moved that the Council authorize the Ad Hoc Committee on Continuing Medical Education to begin approving CME programs that are ongoing in this state and to set up a mechanism for approving new programs. Motion was seconded and carried.—**Referred to Reference Committee on Medical Education and Public Welfare.**

■ Mr. McIntyre said that the AMA Annual Session will be held at the Palmer House in Chicago on June 23-28. Dr. Washburn, senior AMA Delegate, stated that he is calling a caucus for 10:45 on Sunday morning, June 23.

Mr. McIntyre reported that Dr. Joseph White, Columbia, has been recommended to the Board of Trustees of AMA for reelection to the Council on Medical Education.

The Executive Secretary indicated that at least one vacancy and possibly two will occur on the AMPAC Board this coming fall. This Board is appointed by the Board of Trustees of the AMA. It was moved, seconded and approved that the Council go on record as strongly endorsing Dr. Hubert A. Ritter for the AMPAC Board.

Mr. Royal O. Cooper indicated that the Council had approved three new insurance plans—Office Overhead with Eggert-Carroll-Schroeder and Altman-Singleton and Major Medical and Group Term Life with Forrest T. Jones. Staff has been working with these firms and information on the major medical will probably be sent out in July and on the Group Term Life in September and Office Overhead in June.—**Referred to Reference Committee on Reports of Officers.**

■ Mr. McIntyre said that a request had been received from the Missouri Thoracic Society for membership on the Commission on Interspecialty Medicine. The Society has approximately 130 members. All M.D. and D.O. physicians licensed to practice in the state and with an interest i pulmonary diseases are encouraged to join.

It was moved, seconded and carried that the Missour Thoracic Society be placed on the Commission on Interspecialty Medicine. The MSMA President will appoint member of this organization to represent them on th Commission as per their request.—**Referenc Committee on Resolutions.**

COUNCILOR ADVISORS

■ Dr. McAlhany made the following appointments of Councilors as advisors to the standing MSMA Commissions:

Commission on Medical Economics, Third Party Medicine, and Governmental Relations . . . . . Dr. Hetlage
Commission on Continuing Education and Health Manpower . . . . Dr. McCanse
Commission on Interspecialty Medicine . . . . Dr. Hansbrough
Commission on Public Affairs . . . . Dr. Martin
Commission on Medical-Legal Affairs . . Dr. McAlhany

REPORTS OF DISTRICT COUNCILORS

District #1—Dr. Martin reported that the Methodis Hospital in St. Joseph has opened its staff to D.O.s. Bot hospitals—Methodist and St. Joseph's—are expanding an many of their services are duplicated.

Dr. Martin stated that he still feels that we are not getting the information from the AMA that we should b receiving.

Districts #2 and #3—Neither Dr. Bach nor Dr. Frankli could be present for this meeting.

District #4—Dr. Hetlage reported that he had held meeting with the delegates in his district with a quoru present and the following matters were discussed:

There was a discussion of a proposed resolution concerning condensation of policy changes into resolutions. It wa the opinion of the group that this was unworkable. However, they did approve the concept and would favor th condensation of Council minutes and Commission report for publication so that these activities can be more easil understood by the members and by the delegates at th annual convention.

The delegates of the Fourth District went on recor as favoring and encouraging the development of malpractic insurance by the state association.

The article in a recent issue of *Medical World New* relative to the AMA Board of Trustees was discussed wit considerable concern. Members of the Fourth District fee that the times require leadership of AMA to be representative of and responsive to the general membership and tha the conduct of the Board should be such as to be not self serving or discriminatory. They requested that the AM Delegates convey this attitude to the Annual Conventio in Chicago in June.

Dr. Hetlage reported that Medicare Bulletin #3 concerning the new "Waiver of Liability" was discussed. On motion of Dr. Hetlage, duly seconded, it was agreed that thi matter be studied in further detail by the Commission o Medical Economics.

On motion, duly seconded, it was further agreed tha this be referred to the AMA and to have them respond t this in the same way they responded to precertification.

Dr. Hetlage reported that his district agreed that MSM should expend its educational efforts on legislative program on which such influence could be effective and not try t change those things which we cannot change. Energy shoul be directed toward useful and productive endeavors.

Dr. Hetlage stated that his district feels that amalgamation of St. Louis County and St. Louis City into a metro litan society is necessary for the proper conduct of medical fairs in the area.

Disproportion of private office fees vs. those paid to ganized clinics, such as medical schools, by the Welfare epartment was discussed at his district meeting. On mo- on, duly seconded, it was recommended that further study this matter be made by the Commission on Medical conomics of MSMA. Motion carried.

Dr. Hetlage reported that Dr. Paul Rother, Chairman of e MSMA Planning Committee, was present at the meeting d the group recommended that some of the changes sug- sted at the meeting be considered by the Planning Com- ittee, such as condensation of minutes and providing more mplete information to the House of Delegates on Council d Commission activities. It was further suggested that the anning Committee recommends to the Committee on onstitution and Bylaws that a hard look be taken at the esent Constitution and Bylaws with the idea in mind that ey be completely revised to bring them up to date with ose of other states.

Dr. Hetlage said that a proposal had been made that the SMA support those health bills in Congress, otherwise esirable, which would require a means for funding those ograms proposed in the bill. That is, if a major program National Health Care were proposed, means for financing is care also would have to be provided in the bill.

Dr. Hetlage proposed that it might be advisable to con- der a change in the Constitution and Bylaws to permit a ice-Councilor in each district and he made the following otion that "The Council request the standing Committee Constitution and Bylaws to investigate the manner and eans of changing the Constitution and Bylaws to permit e election of a Vice Councilor from each district and to port their findings to the Council at the January Council eeting." Motion was seconded and carried.

District #5—Dr. Bregant reported that a grant has been pproved for the Mid-Missouri PSRO Foundation. The quest asked for $50 per hour for peer review physicians' rvices. However, approval has been given for $35 per ur.

District #6—Dr. Bradshaw indicated that he did not ve a report at this time.

District #7—Dr. McCanse stated that the Northwest issouri PSRO is in the process of applying for a PSRO anning grant.

The Jackson County Medical Society Executive Council cently approved an impartial Medical-Legal Review Plan. his involves both the Jackson County Medical Society, steopathic Association and, also, the Kansas City Bar As- ciation and Kansas City Lawyers Association. This Plan s not been approved as yet by all the organizations in- lved.

District #8—Dr. McAlhany reported that 16 hospitals in utheast Missouri have withdrawn as member hospitals of e Blue Cross organization. Rather than the patient assign- g insurance benefits to the hospital, the patient collects e benefit and pays the hospital.

District #9—Dr. Cooper reported that at a meeting of s delegates, there was quite a clamor for more direction om the AMA and MSMA. They do not feel they are get- ng enough information and direction. He also stated that scussion was held regarding the fact that under Medicare, physician has an option of accepting or rejecting assign- ent. However, under Medicaid no such option exists. On otion of Dr. Cooper, duly seconded, the Council agreed at the concept of assignment option should come along ith any new major health insurance plan.

District #10—Dr. Hansbrough indicated that the *Cape irardeau County Medical Bulletin* is giving him, as District Councilor, a page in the *Bulletin* each month and he is pleased. He suggested that the other county journals in the state might wish to do this also for their Councilors.

Dr. Hansbrough expressed his concern regarding Missouri Medicine and indicated that he certainly does not like the possibility of combining the journal with other state journals. He suggested that an editorial be written for Missouri Medicine soliciting readership in the MSMA Journal and explaining the process that is taking away our advertising. This is to be left to the discretion of the Publications Committee.

REPORT OF THE PRESIDENT

President Cope stated that the House of Delegates had approved a dues increase of $25 beginning in 1975 and asked the Council if some of the new programs should be started immediately, which might mean borrowing money.

Dr. Cope said that, unfortunately, the Annual Banquet each year turns out to be a stereotype and it is his feeling that this should be an affair in which people are interested and look forward to attending. Staff looked into the cost of getting a nationally known speaker—for instance, one charges $5,000 and pays his own expenses. Other programs vary considerably in cost.

Dr. Cope reported that he had received a letter from the Governor stating that he had been contacted by the Regional Director of HEW requesting the state to consider the possible development of a planning contract with HEW on the regulatory role Missouri government might perform in health resources planning. A letter was written to the Division of Health, as requested by the Governor, indicating that if it is decided to explore the possibility of a state contract with HEW to begin a planning program, we would like to have an active role in this exploratory activity. It is understood that at the present time, there are no funds available for this activity.

Dr. Cope indicated that he has information that the undergraduate M.D. degree program, the Internship and Residency for Family Practice, Medicine, Gynecology and Pediatrics at the University of Missouri have been relegated to a Priority II in the tentative academic plan. This area had previously held a rating of I-A. Dr. Cope wrote a letter to the Board of Curators expressing the Association's concern in this matter. A reply was received indicating lack of funds to be the reason for the lower priority rating. Another letter was written to the Board in answer to this reply.

It was the feeling that the M.D. program and primary care program should be top priority and that it was most appropriate for the Council to communicate with the Board of Curators fully supporting Dr. Cope's letter. Dr. McAlhany stated that with Council approval, such a letter to the Board of Curators will be drafted to be signed by the Chairman of the Council.

REPORT OF THE WOMAN'S AUXILIARY

Mrs. Lytton thanked the Medical Association for its support of the Auxiliary's Annual Convention and 50th Anniversary celebration held during the session. She indicated that attendance at the meeting was very good. A booklet has been printed, "50 Years of Service," and it is very interesting to see what went into the Medical Auxiliary beginning 50 years ago. Mrs. Lytton reported that a new approach was tried at the Auxiliary Annual Meeting by having workshops and apparently this worked out very well.

Membership in the MSMA Woman's Auxiliary has declined to the point where a delegate has been lost to the national convention. She asked the physicians to please encourage their wives and other physicians' wives to join and pointed out how much more could be accomplished with a larger membership. The Auxiliary contributed $18,-

484.70 to AMA-ERF during the past year.

On motion, duly seconded, the Council went on record as favoring an increase in membership in the Woman's Auxiliary and recommends to each county society that it study the possibility of billing for Auxiliary dues jointly with its county society dues.

Dr. Hetlage then brought up a point in President Cope's report regarding whether anticipated new programs should be implemented prior to the dues increase in 1975.

On motion, duly seconded, it was agreed that the Executive Committee go ahead and develop the new programs as expeditiously as possible.

ACTIONS OF THE MSMA HOUSE OF DELEGATES

Dr. McAlhany indicated the disposition of the resolutions passed by the 1974 House of Delegates which are as follows:

Resolution #2—Seat Belt Legislation—Referred to Legislative Committee for further study.

Resolution #3—Hospital Medical Staff Autonomy—To appear in MSMA Journal and councilors to inform constituents.

Resolution #5—MSMA Parliamentary Procedure—Referred to standing Committee on Constitution and Bylaws.

Resolution #8—Discriminatory Fees—Sent to State Insurance Commissioner.

Resolution #13—Hospital Governing Board and Medical staff Relationships—Publish a summary of the Darling Case in Missouri Medicine.

Resolution #14—Involvement of Third Parties in the Practice of Medicine—Referred to Commission on Medical Economics.

Resolution #16—Improved Communications with the Membership of MSMA—Executive Committee will implement this.

Resolution #17—Use of Combination of Drugs—Has been sent to AMA and FDA.

Resolution #18—National Health Insurance—Has been sent to AMA.

Resolution #1—Pre-Admission Certification—Letter sent to AMA commending their action on this.

Resolution #20—Physician Involvement in CHP—To be sent to County Medical Societies and request societies to return information to Commission on Medical Economics.

Resolution #21—Cost of Living Council Regulations—Copies sent to Missouri Congressional Delegation.

Resolution #22—Malpractice Insurance—The Council was requested by the House of Delegates to attempt to develop a malpractice program for its members as soon as possible. Dr. McAlhany named the following Ad Hoc Committee on Professional Liability in order to develop and facilitate this program: Drs. Irving Clark, Kansas City, Chairman; Robert L. Willcoxon, Joplin; Jerome I. Simon, St. Louis; R. Allen Chandler, Kansas City; and Howard McAlhany, Springfield. Mr. Cooper indicated that we do have some material to be given to the committee so that they could commence.

Resolution #23—Insurance Coverage for Mental Illness—Referred to Legislative Committee.

Resolution #24—Drunk Drivers—Referred to Legislative Committee.

Resolution #28—Legislation to Teach Human Physiology in Secondary Schools—Sent to State Department of Education.

Resolution #29—Apply PL 92-603 (Section 249F) to Government Hospitals in Missouri—Sent to HEW, AMA and Social Security Administration.

Resolution #30—Ratify the Equal Rights Amendment—Sent to General Assembly.

Resolution #31—Complete Maternity Coverage—R ferred to Legislative Committee.

Resolution #32—Politics in VA Hospitals—Sent to HE and AMA.

Resolution #33—Coordination of AMA-ERF Fund R cipient with Practicing Physician—Has been forwarded AMA and will appear in AMA Handbook for Annual Co vention.

Resolution #35—Support of House Bill 1254—Tl MSMA did support this both in the House and Senate.

Resolution #36—Repeal of PSRO Legislation—Sent Missouri Legislators, President, Missouri Congression Delegation and Secretary of HEW.

Resolution #38—Constitutional Convention—Referred Committee on Planning.

Resolution #40—Unified Membership with AMA—R ferred to standing Committee on Constitution and Bylav for write-up of necessary changes in present Constitutic and Bylaws. Will be published several times in Journal.

Resolution #41—Opposition to U. S. Senate Bill 29 and U. S. House Bill 12053—Copies sent to AMA ar Missouri Congressional Delegation.

MSMA-SPONSORED TOURS

Mr. Cooper reported that the June 26 trip to Mid-Euro has been sold. Our August trip to Greece has approximate 30 reservations. A trip to Barbados with Marriott Wor Travel has been planned for November. Mr. Cooper stat that the Travel Committee had received the following pr posals for 1975 trips: A Russian trip in October, 1975, 14-day African trip in January or February 1975 and Adriatic trip.

REPORT OF THE DEANS

Dr. Stoneman of St. Louis University indicated that he concerned with Senate Bill 392 which was passed duri the last Session of the Legislature. This bill relates to tl use of patients or inmates of certain institutions in researc and experimentation. He stated that certain parts of tl bill were unworkable.

Dr. Domke stated that with some of the responsibiliti given to the Division of Health under this bill, it wou make the bill impossible to administer with the prese staff at the Division of Health.

Dr. Cope stated that MSMA has a Liaison Committee work with the Executive Branch of Government and if tl Council so desired, this committee could be directed convey to the Governor our feelings that this bill should vetoed.

Dr. Hetlage moved that the Liaison Committee take o desire in regard to vetoing Senate Bill 392 to the Governc Motion was seconded and carried.

Dr. Mayer stated he had feelings similar to those e pressed by Dr. Stoneman in regard to Senate Bill 39 Dr. Mayer indicated that there is growing interest on tl part of graduates from medical schools to enter fami practice.

Dr. Guze reported that Washington University had gra uated a class of 114. A growing percentage of graduat have elected to take their house staff training in fami medicine.

Dr. McCanse stated that he would report for Dr. Noba and the University of Missouri Kansas City School of Med cine. UMKC has accepted 72 students for next fall. Tl formal dedication of the UMKC Medical School buildi will be held on October 27. Dr. McCanse indicated that tl Council and Officers will be invited to attend.

REMARKS OF THE DIRECTOR OF THE DIVISION OF HEALTH

Dr. Domke stated that Mr. Lawrence Graham has be pointed by the Governor to serve as the Director of the w Department of Social Services, under which the Divi-n of Health and Board of Health will operate.

Dr. Domke stated that he had previously asked the uncil for assistance in regard to a family planning pro-am for the state. A committee chaired by Dr. Hetlage was pointed and had made a report to the Council. Even ough some attempt had been made to organize the various nily planning programs in the state, it has been decided HEW that the present system of family planning will ntinue this year.—**Referred to Reference Committee on ports of Officers.**

Mr. McIntyre stated that he understood that the Board of alth will require that all hospitals join in a uniform hos-al admission and discharge system. Dr. Domke had ap-inted a special committee to study various plans through-t the country and the committee decided on the Iowa thod. The Committee will recommend that the name of patient and the doctor not be revealed except by in-idual hospital code and with this code to remain con-ential.

The Committee reports that this system will request each spital to forward 15 various items of information. The mmittee further submits the following recommendations:

1. It is strongly recommended that the Missouri State Medical Association ask the Department of Health for a copy of this committee's recommendations.
2. It also recommends that the Missouri State Medical Association get adequate representation on the committee and future committees that may be set up to study this situation.

Dr. Domke stated that he had no objections to the two ommendations. This system is necessary as a means of ting adequate information about the use of hospitals. e Division has operated a program for about ten years, has not been able to get 100% participation.

Dr. Hetlage moved that the two recommendations men-ned above be adopted. Motion was seconded and carried.

EPORT ON STATEWIDE HEALTH MANPOWER CONFERENCE

Dr. Bradshaw stated that the MSMA had been well repre-ted at the Conference held in Jefferson City on April 23. Governor Bond and several speakers occupied the t morning. In the afternoon, the group broke into work-ps covering topics such as family practice, long range nning, nursing, allied health, physician assistant, dental istant and educational coordination. Each workshop orted back on the second day.

Dr. Bradshaw stated that he chaired the family practice rkshop and that group made the following recommenda-ns:

The developing data collection study on physician manpower created by the Division of Health and by Dr. Hobbs' group at the University of Missouri is to be strongly endorsed and urged to develop ongoing data collection studies which can provide reliable documentation of trends in health manpower.

The group endorses the current cooperative efforts of the Division of Health, the Comprehensive Health Planning Agency, the Missouri State Medical Association, the Missouri Osteopathic Association, the Missouri Hospital Association and the Missouri Academy of Family Physicians in appointing an ad hoc committee to make specific recommendations concerning family physicians for Missouri.

The group recognized that it addressed only one component of a much larger issue of health manpower for Missouri and recommended that comparable efforts be undertaken to look at manpower needs in other health fields.

Dr. Bradshaw stated that a special committee is being set up under the leadership of the State Board of Health to help solve the problem of physician manpower in family practice in the state of Missouri.—**Referred to Reference Committee on Medical Education and Public Welfare.**

PSRO

■ Dr. Chandler introduced Mr. Sam Wheeler, PSRO consultant for the Region VII Office of HEW in Kansas City. Mr. Wheeler stated that the quality of medical care in this country is uneven and, in some instances, far below what the majority of physicians recognize as appropriate.

PSROs will be controlled by the medical profession; standards of care will be developed by those in the profession; the work of a physician will be reviewed only by physicians; any action against an individual to improve the quality of his work will have to be taken by the profession itself and there is an extensive appeals process.

Mr. Wheeler reported that many contract applications for PSROs were received by May 1. Total contracts received nationally were 107 and contracts for ten statewide support centers also were received. Missouri was divided into five PSRO areas and the Missouri Health Care Foundation has submitted an application for a statewide support center. The statewide support center would provide technical support to the five local PSROs. It will not run local PSROs and will come in only if a local PSRO asks for help. He pointed out that specialty societies were working on criteria for use by PSROs. Mr. Wheeler stated that many physicians still have little or no understanding of PSROs. Purposes of the PSRO program are to (1) Have the medical profession develop appropriate standards of care; (2) Insure the same professional conduct and delivery of care throughout the country; (3) If standards are not adhered to, find out why and if necessary take corrective actions. The appeal mechanism starts at the local PSRO Board, then goes to the state PSRO council, the National PSRO council, the Secretary of HEW and then to the courts.

Mr. Wheeler stated that repeal of the PSRO law in his opinion will not happen without there being another system to replace it. The answer is not in repeal, but in sensible modification where it is appropriate.

Mr. Wheeler stated that strong regulations in regard to confidentiality of records had been built into the law. He indicated that PSRO could be a protective shield against malpractice because of agreement on professional standards. Establishing such standards regionally in the country could help free physicians from malpractice. The PSRO program was set up as a quality improvement program, but it is believed that cost reduction will be the result.

Dr. Hetlage stated that several states had taken a nonparticipation attitude in regard to PSRO and asked what would happen in these instances. Mr. Wheeler stated if no PSRO mechanism has been set up by January of 1976, the Secretary of HEW would pick out an appropriate institution, agency or group in the area to do the job. Mr. Wheeler outlined several types of review that will be done. A question was asked as to what it is costing to manage the PSRO program.

Mr. Wheeler stated that this year, the cost is about $30 million and is expected to go up to $55 million next year. A question was asked as to how it would be decided what would be an appropriate fee for physicians doing review. Mr. Wheeler stated that this wouldn't be decided until a norm has been established. Mr. Wheeler pointed out that the program was four to six months behind schedule.—**Referred to Reference Committee on Resolutions.**

REPORT OF THE COMMITTEE ON LEGISLATIVE AFFAIRS

■ Dr. Matthews stated that the following bills supported by MSMA had been passed during the last session of the General Assembly:

A *"Sick Doctor" bill,* which has been signed by the Governor. This provides that the Board of Healing Arts can require a "sick" physician to meet certain criteria to continue to practice. The bill is designed to protect the public and to salvage "sick" physicians.

Insurance for Newborn was approved, but has not been signed as yet by the Governor. This bill provides that all individual and group health insurance policies would automatically afford coverage for newborn children of the insured from moment of birth.

The physical therapists licensure bill has been signed by the Governor. This law strengthens the present law by prohibiting a person not licensed as a physical therapist from representing himself as a physical therapist.

The Governor's bill on high-risk maternity and prenatal care was combined with a state aid for public hospitals bill and passed. It has not been signed as yet. The bill provides state aid to public hospitals. The bill also provides for a program of care for women who have a high risk of developing conditions leading to premature births or who might produce mentally retarded children. Program includes diagnostic and treatment centers for such women.

Other bills of interest considered during the last Session are as follows:

An abortion bill was passed, but has not yet been signed. The bill provides that no abortion could be performed in the first 12 weeks except by a licensed physician with the consent of the woman, her spouse or a parent if she is under 18 and unmarried. Abortions after the first 12 weeks must meet the same criteria and be performed in a hospital.

"Patients Rights" bill was passed. It prohibits the use of or participation of inmates or patients of state correctional, mental or other institutions in clinical research projects without the informed consent of the patients or inmates or certain relatives or guardians. Depending on the nature of the research, the approval of the Division of Health or Division of Mental Health also might be required. This bill has not been signed.

Several bills calling for the repeal of the 1973 ambulance law were not passed. An acupuncture bill and a bill that would have greatly expanded crippled children services were not passed. A bill calling for the removal of the words "by hand" from the chiropractic practice act and a physical therapy bill which would have opened the practice of physical therapy to chiropractors also were not passed.

Dr. Matthews stated that a $50,000 planning bill for an optometry school located in St. Louis was passed and signed by the Governor.

Dr. Domke stated that under state reorganization, the Board of Health and the Division of Health would be a part of the new Department of Social Services as of July 1.

Dr. Matthews also reported that the following bills of interest were not passed: Delegation Amendment; Insurance for Psychiatric Care; Mandatory Seat Belt Usage; Use of Generic Name of Drugs on Prescriptions; Treatment of and Insurance for Alcoholism; and a bill to regulate and license Clinical Laboratories.

Legislative matters proposed by the House of Delegates for 1975 include support for seat belt usage, support for insurance for mental illness and support for complete maternity coverage insurance.

Dr. Matthews stated that an Interim Committee of the Missouri House and Senate has been established to consider, investigate and study the areas of physician assistants, medical laboratories, acupuncturists, surgi-centers and other related matters in respect to the possible need for licensure
and regulatory legislation. Dr. Matthews asked Counc
approval for the President to be empowered to appoint a
hoc committees in each of the above mentioned areas s
that we may be prepared to present proposals in these area
when asked to do so by the Interim Committee.

A motion was made, seconded and carried that suc
ad hoc committees be appointed in the areas of physicia
assistants, medical laboratories, acupuncturists and surg
centers.

Dr. Matthews expressed his thanks to Messrs. Royal
Cooper, Cork Swarens and Ray McIntyre for their assistan
during the Legislative Session. Dr. Matthews stated that w
had gotten 80% of our total program through the Legi
lature and that this is quite an accomplishment.—**Referre**
to Reference Committee on Miscellaneous Affairs.

PRACTICE MANAGEMENT WORKSHOP

■ Mr. Swarens reported that the Practice Managemen
Workshop was held in St. Louis on May 6 and 7. Th
workshop provides information on establishing yourself
medical practice. Eighteen people attended and expresse
extreme pleasure with the information provided. Mr. Swa
ens stated that the AMA is going to reassess this progra
to see if it can sponsor more of these later and, perhaps, w
should consider having another one if they are again offere
Mr. McIntyre indicated that he would like to commen
St. Louis Medical Society for their assistance in handlin
this workshop.

REMARKS OF THE SPEAKER OF THE HOUSE OF DELEGATES

Dr. Slickman stated that there was general agreeme
that the sessions of the House of Delegates went extrem
well this year and that he could not foresee any chang
next year. He did indicate that the reference committe
might meet a little earlier on the first day. Dr. Chandl
stated that he would like to commend the Speaker for
job well done.

NEXT COUNCIL MEETING

Dr. Chandler stated that the next meeting is tentativ
scheduled for the middle of September at the Alame
Plaza in Kansas City.

The meeting was adjourned.—**Referred to Referen**
Committee on Reports of Officers.

Meeting of Sept. 14, 1974

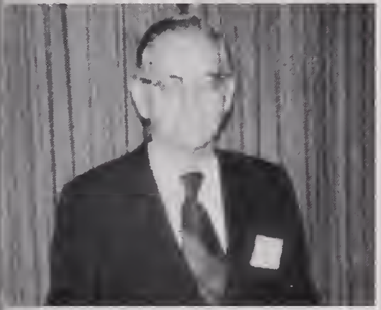
■ Max S. Franklin, M.D., St. Louis, Chairman, called t
meeting to order. Those present were Drs. Franklin; Jam
C. Cope, Columbia; R. Allen Chandler, Kansas City; Jo
I. Matthews, Jefferson City; Donald R. Judd, St. Lou
E. A. Stricker, St. James; Lysle M. Bach, Hannibal; Lo
P. Hetlage, Troy; Robert E. Bregant, Jefferson City; Willia
D. Bradshaw, Clinton; Andrew McCanse, Kansas Ci
Howard J. McAlhany, Springfield; Claude W. Coop
Thayer; Eugene T. Hansbrough, Poplar Bluff; Robert
Slickman, Kansas City; James T. Brown, Springfield; Stan
S. Peterson, Springfield; Hector W. Benoit, Jr., Kansas Ci
J. Loren Washburn, Versailles; Hubert A. Ritter, St. Lo
M. Kenton King, William Stoneman, III, and Geor
Thoma, St. Louis; Richardson K. Noback, Kansas City; W
liam C. Allen, Columbia; Irving H. Clark, Kansas Ci
Herbert R. Domke, Jefferson City; Mrs. George J. Lyt
and Mrs. William R. McPhee, Kansas City; Messrs. Ja
L. Hamilton and Timothy J. Danis, St. Louis; Al Lern
Chicago, Ill.; Hollister S. Smith, St. Louis; Gary
Schnedler, Springfield; Allen D. Smith and Roger A. W
Kansas City; Messrs. Ray McIntyre, Royal O. Cooper, C.
Swarens, Ron Ellison and Don Wilson, Staff.

On motion, duly seconded, the minutes of the May
1974 Council Meeting were approved.

MSMA Annual Session Presents 24 Scientific Sessions

Thomas F. Frawley, M.D. *(center)* moderated the Friday ession for the Missouri Society of Internal Medicine and he American College of Physicians (Missouri Region). Paricipants included Edward D. Kinsella, M.D. *(left)*, Associate linical Professor of Medicine, St. Louis University and Louis violi, M.D., Shoenberg Professor of Medicine at Washingon University. Dr. Frawley is Past-Governor for Missouri, merican College of Physicians.

The Missouri Heart Association presented the following speakers: *(left to right)* Robert L. Frye, M.D., Rochester, Minn., Chairman, Cardiovascular Disease, Mayo Clinic; and Duncan A. Killen, M.D., Professor of Surgery, University of Missouri-Kansas City. Ben D. McCallister, M.D., Kansas City, served as moderator. Dr. Frye discussed "Studies on the Objective Results of Coronary Artery By-Pass Surgery Graft Patency, Coronary Blood Flow, Survival—The Cardiologist's View."



Gordon C. Sauer, M.D., Kansas ity, served as moderator for a sesion on "Common Skin Diseases, Ianagement Pearls" sponsored by he Missouri Dermatological Society n Saturday.

Jean Chapman, M.D., Cape Girardeau, President of the Missouri State Allergy Association, presided at the Allergy Association's session on Friday and gave the opening remarks.

First speaker on Dr. Chapman's panel was Max Samter, M.D., Chicago, Professor of Medicine, Abraham Lincoln School of Medicine and Director, Institute of Allergy and Clinical Immunology, Grant Hospital.

Participants on Dr. Sauer's panel were *(left to right)* ruce V. Drowns, M.D., Kansas City; Norman Asel, M.D., olumbia; Wilfred E. Wooldridge, M.D., Springfield; and ames C. Sisk, St. Louis.

Robert E. Hermann, M.D. *(left)*, Cleveland, Ohio, Head of the Department of Surgery, Cleveland Clinic, was the Speaker for the Missouri State Surgical Society on Friday. John S. Spratt Jr., M.D., Columbia, served as moderator.

REPORT OF THE EXECUTIVE SECRETARY

Mr. McIntyre introduced Mr. Don Wilson who is the new Field Secretary for the Missouri State Medical Association.

Mr. McIntyre stated that Dr. Joseph Cope of Lexington and Dr. John Martin of St. Joseph have recently been appointed to the State Board of Registration for the Healing Arts by Gov. Christopher Bond.

Mr. McIntyre indicated that he would like to secure Council endorsement for a proposed Immunization Action Month. This was originally promoted by the U. S. Public Health Service and was endorsed by the AMA. The month of October has been designated by Governor Bond as Immunization Action Month in Missouri.

On motion of Dr. Bradshaw, duly seconded, it was agreed to give MSMA endorsement for the Immunization Action Month.

Mr. McIntyre reported that a Manpower Study Program is beginning operation in Missouri under the direction of Comprehensive Health Planning. The purpose of the program is to study in detail the health manpower needs of the state and then make recommendations as to what to do and what can be done. A task force has been appointed. Dr. Bradshaw is Chairman of the Task Force and Mr. McIntyre said that he had been appointed to serve on the Task Force with Royal O. Cooper as his alternate.

Dr. Hetlage suggested that an ad hoc committee of the Commission on Medical Economics review the reports of the Task Force which is studying health manpower.

On motion of Dr. Hetlage, duly seconded, it was agreed to request that the reports of the Task Force studying health manpower be made available to an ad hoc committee of the Commission on Medical Economics for review of the activities and information which have been compiled.

Mr. McIntyre reported that the AMA will hold a Continuing Medical Education Conference on October 2-3 at the Drake Hotel in Chicago. Dr. Paul Young and Mr. Ron Ellison will attend the conference.

Mr. McIntyre stated that Dr. John Laird, President-Elect of the St. Louis County Medical Society, has sent out invitations to the officers of the county medical societies for a meeting that will be held at Tan-Tar-A in October. This will not be a formal meeting, but it will be a discussion session of the problems facing county medical societies.

REPORT OF THE TREASURER

Dr. Judd reported that in the Executive Session on Friday night, there was a discussion of the Association's 1974 financial operations through August 31, 1974 in an itemized fashion. There are some items that are not in line with our 1974 adopted Budget primarily because of the extent of inflation which was not fully anticipated by the Budget Committee last December in proposing the 1974 Budget. This was to be a deficit budget, anticipating a deficit of about $5,000. We now anticipate a deficit in the range of $10,000.

REPORTS OF DISTRICT COUNCILORS

District #2—Dr. Bach stated that a mental health center is now operating in his area. A pediatric intensive care unit has been opened in a hospital in Hannibal.

District #3—Dr. Franklin called on Dr. Judd to discuss the possible amalgamation of the St. Louis Medical Society and the St. Louis County Medical Society.

Dr. Judd stated that both societies have discussed the possibility of amalgamation for several years. Both societies were surveyed by an AMA survey team last year and amalgamation was recommended. The societies established a joint committee to look into the feasibility of combining. This committee of both societies recommended amalgamation. The Executive Councils of both societies have vote for amalgamation. A vote of the membership of both societies will be held on October 15.

District #4—Dr. Hetlage presented and then withdrev the following resolution after consultation with the AM Delegates who indicated that this was redundant as this i already AMA policy:

> *Resolved,* That the Council of the MSMA go on record as resolutel favoring a stance by the AMA with the Federal Government whic would require a means for balanced fiscal funding to be written int any proposed legislation for national health insurance or any oth medically oriented proposals; and be it further
>
> *Resolved,* That this resolution be conveyed to the AMA House Delegates for its consideration and action.

Dr. Hetlage presented several reasons why the Fourt Councilor District objected to the new proposed Missou Uniform Hospital Discharge Data Program.

He stated that representatives from CEMPROC attende his Fourth District Conference on September 4 and presen ed an interesting discussion of that new organization.

A discussion on the amalgamation of the St. Louis Cit and St. Louis County societies was held at the Fourth Dis trict Conference. Also, a discussion was held on CME an compulsory relicensure and on the report of the MSM Commission on Medical Economics.

Dr. Hetlage stated that a lively discussion was held at h District Conference regarding the actions of the MSMA A Hoc Committee of the Council on Family Planning, which he is Chairman. There have been objections of inte ference expressed by the St. Louis Family Planning Cou cil. This Family Planning Council, in general, is firmly i control of the medical profession and is doing an excelle job without apparent interference of the private practice medicine in this area. He indicated that it was felt that th report of the Ad Hoc Commitee on Family Planning le the impression with the St. Louis Family Planning Counc that we favored the dissolution of this Council and the a sumption of this function by the State Health Departmen Dr. Hetlage stated that, unintentionally, this was the impre sion that was given in the report. He indicated that he fe it was in order for him, as Chairman of the Ad Hoc Co mittee on Family Planning, to apologize to the St. Lou Council.

The matter of professional liability insurance was di cussed at the Fourth District Conference. Dr. Hetlage ind cated that it was felt that the principle of contingency fe on the part of the legal profession to be a definite cause f the rise in malpractice suits and, thereby, the vast increa in the cost of professional liability insurance. He stated tha perhaps, a committee composed of physicians and lawye should attempt to study and arbitrate all claims for medic malpractice and that the cost of malpractice insuran would be greatly reduced by such action.

Dr. Hetlage reported that those members present wl had been newly appointed to commissions and committe expressed a strong desire to have their duties on these co missions and committees defined so that they may more ad quately carry out their responsibilities.

Dr. Hetlage stated that he had attended the June AM Annual Meeting and was appreciative of the willingness the part of the Missouri Delegation to include him in th activities and of seeing the operation of the delegation fro the inside.

Dr. Hetlage suggested that in order to increase the pre tige of our delegation, following the lead of Texas and oth delegations who were immediately identifiable because their uniform dress, funds be made available to purcha coats of a uniform color with a suitable breast pocket pat for each of our delegates and alternates and that society ficers, and executives be similarly attired. Dr. Franklin stat at the matter of coats for AMA delegates, alternates, socie- officers and executives would be referred to the Planning mmittee.

District #5—Dr. Bregant reported that an office for the id-Missouri PSRO Foundation had been set up in Jefferson ty and that it now has an Executive Secretary. Dr. Paul ung is the project director and they are now formulating embership applications, etc.

District #6—Dr. Bradshaw stated that he had no report present at this time.

District #7—Dr. McCanse reported that the Northwest issouri PSRO now has a planning grant and is in the pro- ss of contacting medical societies and hospitals and ac- ainting them with PSRO and recruiting membership in e PSRO organization.

Dr. McCanse stated that at the last Council Meeting, he d reported on Medical Systems, Inc. This group was in- rporated by some members of the Jackson County Medi- l Society to attempt to provide physicians services to large lustries in the Kansas City area.

Dr. McCanse reported that the greater Kansas City Medi- l Society *Bulletin* had undergone a face-lift recently and asked that it be sent to each member of the Council. Dr. insbrough stated that he would like to receive all Missouri unty medical society bulletins. Dr. Ritter asked that the IA delegates be included on the list of those receiving unty medical society bulletins.

District #8—Dr. McAlhany stated that his Eighth Coun- or District meeting would be held in Joplin on October Dr. Cope will be the speaker. The PSRO in Southwest issouri has had several organizational meetings and plans file for a planning grant.

Dr. McAlhany called on Mr. Gary Schnedler to talk about e new Greene County Medical Society Executive Office. r. Schnedler indicated that the present Executive Office Greene County was too small and that they would move on into larger quarters. He invited everyone to see the w office.

Dr. Franklin thanked Dr. McAlhany for taking over for n at the May Council Meeting.

District #9—Dr. Cooper stated that a doctor in his area d conducted a poll in regard to compulsory membership AMA. A total of 47 letters were sent and 44 responses ere received. Of the 44 responses, 41 disapproved of com- lsory membership in AMA.

Dr. Cooper indicated that there is interest in his area in veloping MSMA group professional liability insurance for embers as quickly as possible.

District #10—Dr. Hansbrough reported that a meeting the National Emergency Physicians was held recently in s area. This was an excellent meeting and is to be an an- al affair.

Dr. Hansbrough stated that his group is moving into a w clinic building soon and invited everyone to see it.

The SEMO PSRO Foundation has been in operation for me time and has several people who are knowledgeable out this. Dr. Hansbrough stated that if any other PSROs ould like advice, there are several people there who will willing to advise them.

Dr. Hansbrough stated that he felt that public health de- rtments should make greater inroads in how to improve ople's health through nutrition. Dr. Bradshaw indicated at a National Conference on Nutrition will be held in olumbia in October. Dr. Hansbrough indicated that he felt at there is not enough public health nursing services and at public health should come up with improved ways of forming people of the dangers of smoking, drugs, alcohol, c.

Dr. Peterson stated that the Extension Division of the University of Missouri, in conjunction with the Health Department and the Medical School, has been having seminars on nutrition in his area.—**Referred to Reference Committee on Reports of Officers.**

REPORT OF AD HOC COMMITTEE TO STUDY GROUP PROFESSIONAL LIABILITY INSURANCE

■ Dr. Irving H. Clark, Chairman of the Commission on Medical-Legal Affairs and of the Ad Hoc Committee to Study Group Professional Liability Insurance, stated that he became involved with this committee approximately four years ago. He stated that, originally, it was felt that Missouri did not have a problem with professional liability insurance, but recommended that a reappraisal of our situation be made if events should change.

Recent developments have made it apparent that we must consider the trend of various underwriting companies in the state of Missouri relative to professional liability insurance. It has become increasingly apparent that the trend of the insurance companies seems to be toward insuring groups of physicians. This is in either county or state associations. It was felt that merely copying one of the plans of other states would be a mistake. Therefore, further study was made.

After interviewing representatives of insurance firms from both Kansas City and St. Louis and other parts of the state who were interested in providing insurance on a statewide basis, the plan which interested us most after the evaluation and study of all was one which would enable the Missouri State Medical Association to evolve a program of professional liability insurance for member physicians which meets several criteria which we had established early in our deliberations. First, it involved the formation of a corporation to be known as the Missouri State Medical Insurance Plan, which should be recognized by Missouri state laws governing insurance sales, that would be administered first of all by the Missouri State Medical Association, with the expertise of management to be provided by this particular firm. Arrangements were to be made to serve other members of the state by means of wide area telephone service.

The administration of the plan should include the promotion of sales of insurance to the membership; the receipt of applications for insurance and necessary processing thereof; the binding of insurance for eligible members consistent with such binding authority as is afforded by the insurance carrier to that company; the delivery of issued policies along with invoices for the premiums; the collection of the premium from the individual insureds; the assistance in the procurement of financing of premiums for individual physicians as may be requested; the routine service of policy changes, such as cancellations, endorsements, claim reports from the physicians and routine service for the individual physician in all matters relating to the insurance policy; the underwriting of the program to be delegated by the insurance company; assistance in the coordination of activities of the Plan; issuance of policies and endorsement thereto with copies to MSMA to the extent desired by its staff; the preparation of accounting records for the insurance company with copies to MSMA to the extent desired by its staff; the handling of all insurance company-agency relations pertaining to the program; the preparation and maintenance of all statistical records with copies of such records to MSMA; the receipt and disbursement of commissions from the insurance company; the provision of advisory service to MSMA to the extent requested; and the general supervision of the Plan to satisfy the requirements of the insurance company.

Responsibilities of MSMA should include the active promotion of new member participation. Needless to say, the previously mentioned responsibilities are those pertaining to the insurance company as a sponsored company with the insurance broker as an active participant. MSMA would promote new membership and be responsible for the performance of liaison services between its members, the plan and the broker, the maintenance of records as required by the plan, the establishment and maintenance of professional liability education program for all members of the association, for it is clear that herein lies the real cure to malpractice litigation problems.

Also, MSMA, as part of its obligation in addition to education for its members, must provide a claims review using independent legal counsel, the cost to be borne by the insurance company, and medical consultant service as deemed necessary to properly serve the individual policyholder and the professional review of the program.

As I go through in my mind the many provisions which were worked out in agreement form with this particular company, several things stand out—that this agreement should remain in effect until it is cancelled; further that the agreement could be cancelled by either member with six months notice prior to January 1 of any calendar year. Now, this does not mean that the insurance is cancelled. It merely makes it possible for MSMA, if dissatisfied, to obtain another administrator or for the administrator to notify us that they desire that we obtain a replacement for them in management of the company. The broker who has advanced this program agrees to join with MSMA in the joint formation of such a corporation and to be responsible for the services described herein under the agreement submitted on a percentage distribution of stock or on a program wherein they would be hired as the administrators of the program for a specified fee. For those of you who are acquainted with the Florida Medical Association program, this is very similar to their program which calls for a 51% ownership by the Florida Medical Association and 49% by the broker involved.

Dr. Clark indicated that this research program was done by Mr. James Hamilton, Vice-President of Rollins Burdick Hunter Company. Rollins Burdick Hunter is the fourth largest insurance broker in North America and is a multinational company. It has a top rating with investment bankers. They are professional buyers and managers of insurance.

Dr. Clark stated that the ad hoc committee is recommending very strongly the concept of the formation of a sponsored insurance corporation, a separate corporation in partnership with RBH or with RBH as manager, for the provision of a professional liability program and/or other related insurances to MSMA members and that they be empowered to continue studies and negotiations necessary to bring about the formation of such a corporation.

Dr. Clark stated that Mr. James Hamilton was in attendance at the meeting and he would like to turn the floor over to Mr. Hamilton for further information and to answer questions.

Mr. Hamilton expressed his thanks to Dr. Clark and to Dr. McAlhany, both of whom have worked with Rollins Burdick Hunter. Mr. Hamilton indicated that what was presented was an interim report. Rollins Burdick Hunter received the following ten charges from the ad hoc committee:

1. Make various assumptions of premiums and losses; examine choices of insurance carriers.
2. Examine various models of allocations of expenses, reserves and premiums, including amortization of acquisition costs.
3. Examine methods of Cash Flow as related to reserving including retrospective rating, dividends, reserve reduction.
4. Construct a Pro Forma financial estimate for five years for the captive agency including profitabil cash flow, investment program.
5. Construct the design of plans and policy language lating coverage and eligibility to rate structure a salability and losses.
6. Design principal features of a marketing plan incl ing advertising, brochures, testing, pricing, includi cost of acquisition.
7. Design principal features of the administration cluding services to members, policy issuance, clai handling, premium collection.
8. Comment on data processing, systems required a software; cost to set up; amount of monthly time.
9. An overall critique from retained mass merchandisi advisors.
10. A report from retained attorneys regarding the va ous legal aspects of a captive agency.

Mr. Hamilton stated that Missouri has a number of ch acteristics somewhat unique from most other states in rega to the malpractice situation. Mr. Hamilton then review various exhibits that had been presented to the Officers a Councilors and answered numerous questions concerning phases of their proposal.

A motion was made by Dr. Bradshaw to approve this port and acceptance of RBH to continue to evolve this p gram in cooperation with the ad hoc committee and MSM

The motion was seconded by Dr. Hetlage and carried **Referred to Reference Committee on Constitution and l laws.**

REMARKS OF THE PRESIDENT

■ Dr. Cope stated that he had received many comments his President's Page in the September issue of Missou Medicine.

He reported that a group of cardiologists from Kan City had circularized hospitals in the state offering th cardiology services. Dr. Cope indicated that he felt it wo be better for hospitals to request this service rather than be solicited.

Dr. Cope said that it had come to his attention tha physician in St. Louis was having problems with Medic in regard to retroactive denial of payments. Dr. Cope sta that he had suggested to the physician that he get a co of the disallowed claims and submit them to the Hea Care Foundation for review. It was suggested that, perha these cases could be submitted to this doctor's hospital ut zation review committee.

Dr. Judd said that if either of the above suggesti proved to be unsatisfactory, perhaps the doctor invol could submit these cases to the Commission on Medical E nomics for an impartial survey.

It was moved and duly seconded that the above mat concerning retroactive denial of payments to a St. Lo physician be referred to the Commission on Medical E nomics.

The motion carried.—**Referred to Reference Commit on Resolutions.**

REMARKS OF MEDICAL SCHOOL DEANS

■ Dr. King reported that the Washington University Sch of Medicine recently admitted a freshman class of 120.

Dr. William Allen reported that Dr. Joseph White asl him to express his regrets for not being able to attend Council meeting and, also, to express his appreciation MSMA for support of him for reelection to the AMA Co cil on Medical Education.

Dr. Allen stated that Dr. Mayer had resigned as Dean the Medical School. He indicated that Dr. Mayer wished express his appreciation to the Council for providing the ɪtunity to meet with them and for the assistance to him the years he was Dean. A search committee has been ap- inted to secure a new Dean.

Dr. Allen reported that Dr. Vernon Wilson has accepted : position of Vice-Chancellor for Health Affairs at Vander- t.

Missouri University School of Medicine has an entering ss of 110 students and approximately one half of these dents came from rural areas of Missouri.

It was moved, seconded and carried that President Cope asked to write a letter to Dr. Bill Mayer indicating appre- tion for his attendance, advice and counsel at Council etings over the past years.

Dr. Stoneman, St. Louis University, reported on enroll- nt at the University stating that the current freshmen ss numbers 151, of which 52 are Missourians.

The search for a Dean of St. Louis University School of dicine is continuing. A Chairman of Internal Medicine ; been hired and will begin in January.

The University expects to begin construction on the rning resources center and it is anticipated this will have large continuing education function at the University. ere is a problem of funding for the University portion of s.

Dr. Noback reported that the University of Missouri-Kan- City has enrolled 72 medical students in year one. He ted that several new staff appointments have been made. . McCanse has been named Associate Dean in the School Medicine. Dr. Noback indicated that he felt that the Uni- sity's preceptor program is going very well.

The University of Missouri-Kansas City School of Medi- ie was awarded a ¾ million dollar grant from HEW to t in place a major program to measure the competence primary care nonphysician practitioners.

Dean Noback reported that they are now in the new dical School Building and extended an invitation to all sent to visit the School. The Truman Medical Center, a 8-bed hospital, should be completed in about two years.

Dr. Noback indicated that the Jackson County Medical ciety has given him a page in their *Jackson County Bulle-* and he is certainly appreciative of this.—**Referred to ference Committee on Reports of Officers.**

EMARKS OF THE DIRECTOR, MISSOURI DIVISION OF HEALTH

Dr. Domke spoke on the Division of Health's involvement the manpower study field, indicating that they are aware the $400,000 grant to CHP, but that the Division of alth has no control over it. The Division is currently in process of a nurses' manpower analysis.

Dr. Domke reported that a group interested in the clini- facilities in Columbia is working to formulate a national, gional cancer center. He is hopeful that papers will have en negotiated by the time of the next Council Meeting.

Dr. Domke has received from HEW a statement concern- the family planning situation in Missouri. It was suggest- that the Association obtain a copy of this statement.

Dr. Domke reported that he understood many questions d arisen regarding the Division of Health proposal for col- tion of hospital discharge data. He stated that the issue confidentiality seemed to be the uppermost issue. Dr. mke said that the Division of Health has been collecting spital discharge data for ten years in cooperation with the ssouri Hospital Association. Approximately 75% of the spitals have been submitting data. The hospital associa- ns in Missouri were consulted and agreed to cooperate in nandatory program in order that data would be available planning of facilities and epidemiologic research. We ll not collect names of patients and there is no provision collect a unique identification number and we will only collect a census tract code. Dr. Domke indicated that the Division of Health is very conscious of the right of privacy and the confidential nature of the data. However, it has been responsible for collecting confidential birth, death and communicable disease records for many years and no violation of confidentiality has occurred.

Dr. Domke said that the previous reporting system known as "Icepick" provided good data from the rural areas, but not the metropolitan areas.

It is clear that there is an increasing interest in hospital planning and construction and the need to control hospital costs and cut down on unnecessary duplication. This is the basic justification for the program.

Much discussion followed regarding the confidentiality of the data collection process, the cost of this program to the hospitals, the usefulness of the data, etc. Dr. Franklin reported that a physician in his area had requested and received a legal opinion regarding the confidentiality of this program. Dr. Bradshaw indicated that he felt the data that is being accumulated will be utilized in such a way as to influence physician manpower and has further-reaching impact.—**Referred to Reference Committee on Medical Education and Public Welfare.**

REPORT OF COMMISSION ON MEDICAL ECONOMICS

■ Dr. Stanley Peterson, Chairman of the Commission on Medical Economics, Third Party Medicine and Governmental Relations, gave the following report concerning his Commission meeting held on Aug. 7, 1964.

Dr. Max Heeb was appointed Chairman of an ad hoc committee to study and implement the resolution approved by the MSMA House of Delegates concerning the negotiation of a definite fee schedule for physicians providing care for Title XIX recipients and further negotiating a list of ancillary services that will be covered for payment by the Missouri Division of Family Services. The legal implications involved in implementing this resolution were discussed at length. The Commission endorsed the principle that under no circumstances should physicians' fees be established solely on the basis of geographic location. The ad hoc committee was directed to obtain from state Medicaid officials a list of items, services and procedures for which providers may not be reimbursed under the Medicaid program.

The Commission discussed disproportionate fees being paid to those in private practice versus those paid to organized clinics and medical school settings. The Chairman will appoint an ad hoc committee to investigate and authenticate any disproportion of fees paid under Medicaid.

The Commission discussed Medicare Bulletin #3, "Waiver of Liability," as issued by fiscal intermediaries in April, 1974 to implement the 1972 Medicare amendments that basically provide that a beneficiary may be "held harmless" for disallowed claims when certain conditions are met. It was the consensus that the category of nonreimbursable services is quite vague and staff was directed to contact the fiscal intermediary and attempt to obtain a list complete with codes of items and services that are considered not reimbursable and, also, to determine from Medicare officials what items and services are considered to be effective and what items and services are considered to be not effective.

Resolution #14, entitled "Involvement of Third Parties in the Practice of Medicine" and adopted at the 1974 Session of the House of Delegates, was referred to the Medical Economics Commission. This resolution states "that all persons or organizations be informed that decisions involving physician care must be discussed with the involved physicians or their representatives before such changes are made."

The Commission recommends that a letter be drafted by staff and directed to all third parties including the federal government, fiscal intermediaries, insurance companies and hospitals. This letter will request them to develop mechanisms that will provide for the involvement of physicians in all decisions involving physicians care before such rulings changes and decisions are made. They should be requested to advise MSMA of the mechanism they have developed to implement this.

The Chairman of the Commission on Medical Economics will appoint an Ad Hoc Governmental Relations Committee in an effort to stay abreast of rapidly changing government programs. This committee will be appointed on a regional basis.

The Commission has attempted to obtain codes from various carriers to enable individual physicians to determine coverage of health insurance benefits. To date, this attempt has been quite unsuccessful, however, staff has been directed to continue this effort as an ongoing project.

Dr. Peterson reported that the Commission has worked for the development of a uniform claim form for accident and health insurance for many years. In 1973, the AMA Health Insurance Claim Form was developed. There was some objection to the statement on the reverse of the form, but this is now being corrected and a new form is available from AMA. Staff was directed to obtain the new forms and send them to all members of the Commission for review and, also, to obtain an opinion from legal counsel concerning this form. It is the Commission's understanding that if a carrier receives a Medicare claim executed on the AMA form it will be processed if it contains the information called for on the appropriate SSA-1490.

The Commission on Medical Economics recommends that an Ad Hoc Committee be appointed to develop a communications program for members and citizens of this state concerning National Health Insurance. Their activities would include articles for the press and other state publications, articles in MISSOURI MEDICINE and a speakers bureau.

The Commission discussed the work of the Missouri State Senate Committee which is conducting hearings throughout the state reviewing the welfare programs. Dr. Peterson developed testimony documenting slow payment to providers for services rendered under Medicaid and on the disparity of payment of physicians for identical procedures and services provided under Medicaid.

The final item discussed by the Commission concerning the Retail Credit Company handling of privileged information between doctor, patient and insurance company. They act simply as carriers between the physician and the insurance company and their files contain only a control sheet listing the source of information and the date it was sent to their customer. They also have indicated their willingness to cooperate with physicians. Staff was directed by the Commission to commend Retail Credit Company for their thoughtfulness in contacting organized medicine and explaining their procedures and to further indicate approval of their handling of privileged information.

A discussion was held following Dr. Peterson's report to the Council and it was suggested that regarding endorsement of the principle that under no circumstances should physicians fees be established solely on the basis of geographic location. Possibly, this should include training.

On motion, duly seconded, it was agreed that the ad hoc committee to develop a communications program for members and citizens of this state concerning National Health Insurance should be assigned to the Commission on Medical Economics.

On motion, duly seconded, the entire report of the Commission on Medical Economics, Third Party Medicine and

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Contraindications: Sulfonamide hypersensitivity; pregnancy at term and during nursing period; infants less than two months of age.

Warnings: Safety during pregnancy has not been established. Sulfonamides should not be used for group A beta-hemolytic streptococcal infections and will not eradicate or prevent sequelae (rheumatic fever, glomerulonephritis) of such infections. Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been reported and early clinical signs (sore throat, fever, pallor, purpura or jaundice) may indicate serious blood disorders. Frequent CBC and urinalysis with microscopic examination are recommended during sulfonamide therapy. Insufficient data on children under six with chronic renal disease.

Precautions: Use cautiously in patients with impaired renal or hepatic function, severe allergy, bronchial asthma; in glucose-6-phosphate dehydrogenase-deficient individuals in whom dose-related hemolysis may occur. Maintain adequate fluid intake to prevent crystalluria and stone formation.

Adverse Reactions: *Blood dyscrasias* (agranulocytosis, aplastic anemia, thrombocytopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia); *allergic reactions* (erythema multiforme, skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis); *gastrointestinal reactions* (nausea, emesis, abdominal pains, hepatitis, diarrhea, anorexia, pancreatitis and stomatitis); *CNS reactions* (headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo and insomnia); *miscellaneous reactions* (drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L.E. phenomenon). Due to certain chemical similarities with some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia as well as thyroid malignancies in rats following long-term administration. Cross-sensitivity with these agents may exist.

Dosage: Systemic sulfonamides are contraindicated in infants under 2 months of age (except adjunctively with pyrimethamine in congenital toxoplasmosis).

Usual adult dosage: 2 Gm (4 tabs or teasp.) initially, then 1 Gm *b.i.d.* or *t.i.d.* depending on severity of infection.

Usual child's dosage: 0.5 Gm (1 tab or teasp.)/20 lbs of body weight initially, then 0.25 Gm/20 lbs *b.i.d.* Maximum dose should not exceed 75 mg/kg/24 hrs.

Supplied: Tablets, 0.5 Gm sulfamethoxazole; Suspension, 0.5 Gm sulfamethoxazole/teaspoonful.

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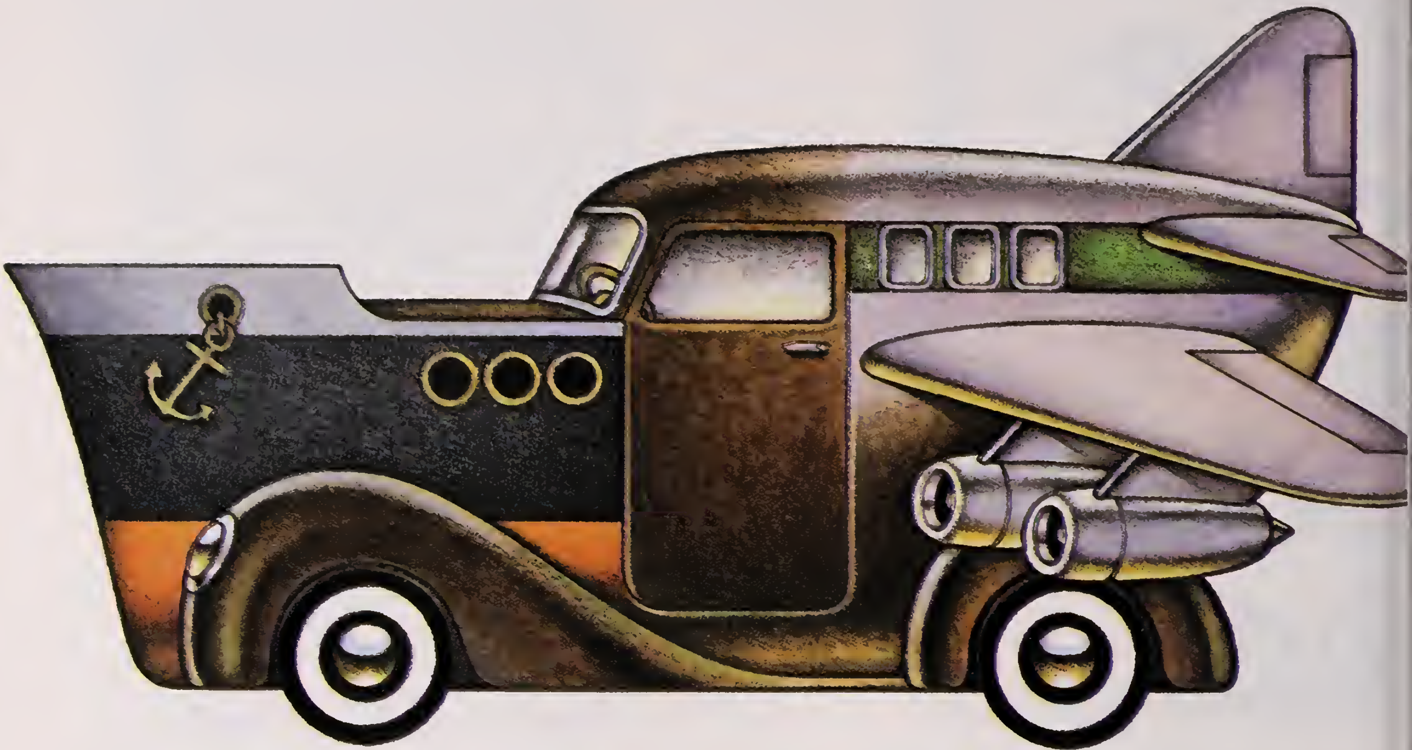

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CONTRAINDICATIONS. Administration of Antivert during pregnancy or to women who may become pregnant is contraindicated in view of the teratogenic effect of the drug in rats.

The administration of meclizine to pregnant rats during the 12-15 day of gestation has produced cleft palate in the offspring. Limited studies using doses of over 100 mg./kg./day in rabbits and 10 mg./kg./day in pigs and monkeys did not show cleft palate. Congeners of meclizine have caused cleft palate in species other than the rat.

Meclizine HCl is contraindicated in individuals who have shown a previous hypersensitivity to it.

WARNINGS. Since drowsiness may, on occasion, occur with use of this drug, patients should be warned of this possibility and cautioned against driving a car or operating dangerous machinery.

Usage in Children: Clinical studies establishing safety and effectiveness in children have not been done; therefore, usage is not recommended in the pediatric age group.

Usage in Pregnancy: See "Contraindications."

ADVERSE REACTIONS. Drowsiness, dry mouth and, on rare occasions, blurred vision have been reported.

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Governmental Relations was approved.—**Referred to Reference Committee on Resolutions.**

REPORT OF THE COMMITTEE ON PLANNING

■ Dr. Cope reported that the Committee on Planning met on August 24, and discussed the importance of long-range planning for the Association. It was the consensus of those present that the work of this committee involves (1) Formulation of long-range goals; (2) Specification of operational objectives; (3) Anticipation of problems; (4) Identification and selection of strategies; (5) Adoption of appropriate policies.

The Committee discussed Resolution #38—Constitutional Convention—which was referred to the Committee on Planning by the 1974 House of Delegates. The possible amalgamation of the two St. Louis Societies was discussed and it was felt by those present that the amalgamation, if completed, would require some reorganization of Councilor Districts and that there is no need to consider a constitutional convention at this time because of the amalgamation situation.

The Committee directed staff to finalize plans for recognition awards for members. Staff will select the type of award to be given and these will be presented to outgoing officers, councilors, AMA delegates, AMA alternate delegates, committee and commission members.

Dr. Cope reported that the Committee recommends that the Committee on Arrangements considers the feasibility of changing the format of our Annual Session. The Committee suggests that Past-Presidents and 50-Year members be honored and recognized at the Saturday general luncheon rather than during the Annual MSMA Banquet on Saturday night and that the media awards also be given at this luncheon.

The Committee recommended going ahead with the New MSMA Policy Manual and that it be revised annually. It also was recommended that this be printed in a manner suitable for mailing to the individual physician rather than including it in an issue of Missouri Medicine.

The Committee discussed the possible use of computer services for dues billing, dues accounting, monthly reports, membership maintenance, roster and typesetting for directories and services and recording of CME credits. It was felt that computer services could be of great advantage for MSMA, and staff was directed to develop proposals on this service for further consideration.

The Committee directed staff to contact the local telephone company to conduct a feasibility study regarding an inward and/or outward WATS line for the Association.

Discussion by the Committee was held regarding Association Vice-Presidents. It was felt that the present position of Association Vice-President is mostly an honorary designation. It was suggested that possibly they should be invited to Council Meetings and be utilized by the President in attending meetings as his designee and/or being assigned by the President as ex officio members of certain committees and commissions of the Association.

The Planning Committee requests that the MSMA president-Elect, shortly after his election, meet with this committee to discuss his proposed program for his year as President. Perhaps they can be of assistance in helping him accomplish some of his objectives.

On motion, duly seconded, the Council recommended acceptance of the Report of the Committee on Planning. Motion carried.—**Referred to Reference Committee on Reports of Officers.**

REPORT OF THE COMMISSION ON INTERSPECIALTY MEDICINE, CME AND HEALTH MANPOWER

■ Dr. McCanse gave a brief rundown on the activities of these two commissions and indicated that this is only an interim report.

The Councilor District representatives went over the continuing medical education plan proposed for the MSMA members. This plan is voluntary. The responsibilities of the district representatives were outlined. It was pointed out that in order for continuing medical education to be effective, it will have to be done mostly in a local setting, such as in hospitals. Mr. Ellison indicated that he visited the AMA office in Chicago and received assistance on what type of certification CME proposal might be the best for Missouri. He received one proposal which he felt, with a few modifications, would fit the Missouri situation. A subcommittee has been appointed to go over this proposal and make the necessary additions, deletions, etc. This subcommittee will report back to the full Committee and then to the MSMA Council.

The Ad Hoc Committee for the 117th Annual Session developed the basic policy for reimbursement of expenses and honorarium to speakers during MSMA Annual Sessions. The one general session at the upcoming annual meeting will have a topic of National Health Insurance and speakers on this topic are now being sought.

Mr. Ellison asked that the Councilors inform the MSMA office as soon as they have decided on what food functions they will need for their Councilor District during Annual Session.—**Referred to Reference Committee on Medical Education and Public Welfare.**

COMMITTEE ON ARRANGEMENTS

■ Dr. Franklin appointed the following members to the Committee on Arrangements for the 117th Annual Session: Max S. Franklin, M.D., Chairman; Louis P. Hetlage, M.D., and Howard J. McAlhany, M.D., Co-Chairmen.

REPORT OF MSMA WOMAN'S AUXILIARY

Mrs. Lytton introduced Mrs. Mary Kay McPhee, President-Elect of the MSMA Woman's Auxiliary, to the Council. The Fall Conference of the MSMA Woman's Auxiliary will be held October 23-24. The President and President-Elect will attend a National Leadership Training Seminar in Chicago during October. Also, there will be a North Central Regional Workshop in Chicago in October.

The Environmental Protection Agency has asked to present a part of the Fall Conference and is also asking the Auxiliary to appoint a county EPA official. These appointees will be asked to attend a seminar on solid waste. Funds are available for these programs to be developed.

Mrs. Lytton reported that the Medical Assistants group has asked to assist the Auxiliary with legislation and indicated that she was seeking MSMA approval for this. It was pointed out that certainly any assistance they could receive would probably be helpful when properly directed.

REPORT OF AMA DELEGATES

Dr. Washburn reported that a summary of events of the 1974 AMA Annual Convention has been published in the *Journal*. However, he listed some of the highpoints.

First, of course, the AMA's stand on PSRO was channeled in the direction of "seeking constructive amendments" to the present law. The new stand does allow room for those states which have voted nonparticipation and concludes by stating that if PSRO proves to adversely affect patient care, the AMA will use all legal and legislative means to rectify the problems.

The previous AMA stand adopted in Anaheim called simultaneously for active leadership in implementation, amendment of the law and finally, repeal of the law. It definitely needed to be changed. Although debate was hot and heavy in the Reference Committee, when PSRO reached the House, an early call for a vote was passed and the new policy was adopted overwhelmingly.

Following the anti-climax over PSRO, the election of Officers and Trustees *did* provide major changes and, perhaps, surprises.

The House changed the method for selecting Trustees from "slot" elections to "simultaneous" elections, thus pitting all 11 candidates against each other for the six open positions on the Board.

In a lengthy election process, only one of three incumbents, Ray Holden, was returned to the Board. Also, Max Parrott, newly elected AMA President-Elect, narrowly held off a last minute campaign by Dick Wilbur to win the post by two votes. Obviously, the articles published in *Medical World News* concerning internal affairs of the AMA had an impact on the elections.

Other items of interest include the successful reelection bid of Dr. Joe White to the Council on Medical Education and the referral of Missouri's resolution concerning "Coordination of AMA-ERF Fund Recipients and Practicing Physicians," which was lauded for its intent and referred to the AMA-ERF Board for study and recommendation.

As I am sure you are aware, there are a lot of important activities carried out at AMA Conventions besides the Sessions of the House. Reference Committees must be attended and reported on, caucuses must be held (usually very early in the mornings) to discuss our stands, satellite meetings on a variety of important subjects must be manned, someone must set up a schedule and escort our candidates around to meet other delegations and, of course, all of us must act a hosts during our hospitality gatherings.

Therefore, the Delegation would like to thank those people who expended their time and energy in our behalf and your behalf at the Convention.

Regarding our hospitality room there is a possibility that due to limited space at the Portland Hotel, we will combine with Kansas, Arkansas and Oklahoma to sponsor one "open house." However, we will have our own meeting room.—Referred to Reference Committee on Reports of Officers.

REPORT OF THE COMMITTEE ON LEGISLATIVE AFFAIRS

■ Dr. Matthews reported that four counties have now tee of the Legislature that is to study acupuncture, physician assistants, surgicenters and medical laboratories has not met, but it will probably have hearings after the general election in November.

Dr. Matthews stated that the Council had established a policy that acupuncture was the practice of medicine. Such a policy also was adopted by the Board of Healing Arts. Dr. Matthews stated that MSMA should reaffirm our position on acupuncture. The Board of Healing Arts should be asked to reaffirm its policy and, possibly, consider promulgating guidelines, rules and regulations regarding acupuncture and also ask for an Attorney General's position regarding this.

It was moved, seconded and carried that the MSMA ask the Board of Healing Arts to reaffirm its position on acupuncture and possibly consider promulgating guidelines, rules and regulations on acupuncture and ask the Attorney General for his opinion regarding this position.

Dr. Matthews stated that the National Board of Medical Examiners is developing guidelines for the registration of physicians assistants. He stated that at present, perhaps our position should be to go along with the National Board of Medical Examiners registration of physicians assistants and that licensing of assistants be deferred.

Dr. Matthews reported that a surgicenter bill is ready and is going to be prefiled. This bill will establish surgicenters in Missouri. The bill will be supported by the Association on the basis of previous endorsement of this principle.

A bill calling for licensing of medical laboratories was introduced in the last session of the General Assembly, but did not pass. Regulations of the conditions for coverage of services for independent laboratories appearing in the *Federal Register* in July are nearly identical to the medical laboratory bill introduced last session. Any bill introduced and adopted by the Legislature would have to comply with federal laws and, perhaps, it would be better to wait a year or two and then pass legislation that would conform with federal requirements.

Dr. Matthews indicated that a report from the Committee on Midwifery had been adopted at the April 3 meeting of the Council. An Attorney General's opinion was issued in 1972 regarding this. The Attorney General's opinion indicated that midwifery is the practice of medicine and the medical practice act would have to be changed in order to provide for nurse-midwives. Dr. Matthews stated that at this point he felt that this matter should be referred back to the Committee on Midwifery for further study.

Dr. Matthews stated that several resolutions were passed during the last session of the House of Delegates which called for legislation on several items. These are Resolution #2—Mandatory Seat Belt Law; Resolution #23—Insurance Coverage for Mental Illness; and Resolution #31—Complete Maternity Coverage under Health and Accident Policies. Legislation will be introduced on all these subjects. The House of Delegates also adopted Resolution #24 which calls for support for legislation introduced to discourage driving while intoxicated.

Dr. Matthews stated that a bill may be introduced that calls for the authorization under the Uniform Anatomical Gift Act to be printed on the reverse side of Missouri motor vehicle operators and chauffeurs licenses.

Dr. Matthews stated that several legislators have asked if we would like for them to introduce good samaritan legislation because of the Attorney General's opinion that it was not properly enacted through passage of the ambulance bill.

Legislation may be introduced proposing a change in the Missouri two-year statute of limitations.

It was moved, seconded and carried that this report be accepted.

REMARKS OF THE CHAIRMAN, BOARD OF REGISTRATION FOR THE HEALING ARTS

Dr. James Brown, newly appointed Chairman of the State Board of Registration for the Healing Arts, said that he would be happy to relay any messages that the Council wished to send to the State Board.

Dr. Brown said that the major problem facing the Board is the influx of foreign medical graduates. At the time it was ruled that citizenship was not a factor for licensing of doctors in Missouri, it was felt that the Board's examination was not difficult enough and so two years ago, the Board switched to the FLEX examination. Medical Schools in the state are now utilizing the National Board examinations and by the time a student has graduated from medical school, he has completed two parts of the three-part national board examination, and usually completes the third upon graduation. Thus, most of those taking the FLEX examination from the Board of Healing Arts are foreign medical graduates. Because of this, the State Board of Registration for the Healing Arts feels that some changes need to be made in the state licensing law.

Dr. Brown stated that he didn't feel that the State Board could be of much help in the acupuncture situation. He indicated that the problem would be how do you license someone for a particular specialty when no guidelines of education have been set up and there are no schools in the country that teach it.

Dr. Cope said that the Legislative Committee wanted the Board of Healing Arts to reaffirm its previous statement that acupuncture is the practice of medicine and ask for an Attorney General's opinion favorable to that statement.

Dr. Brown indicated that the Board of Healing Arts had not done anything with the physician assistant problem because there is no consensus of education from state to state in regard to registration or licensing for these people.

Dr. Matthews said that the Legislative Committee would like for the Board of Registration for the Healing Arts to recognize the National Board of Medical Examiners examination covering certification of medical assistants and then promulgate rules and regulations on how they will be certified in Missouri.—**Referred to Reference Committee on Miscellaneous Affairs.**

MSMA TRAVEL COMMITTEE

■ Dr. Cooper stated that the Travel Committee recommends the following two trips for 1975: a 14-day trip to Africa in February of 1975 and a trip to Canada and Alaska in August or September, 1975.

It was moved, seconded and carried to sponsor these two trips.

Mr. Al Lerner, new Field Representative from the AMA, brought the Council up to date on NHI. He stated that because of the large number of health oriented bills in Congress and state legislatures, the AMA has set up a program called "Action 74" and is urging each state to form an ad hoc committee that will have expertise on this type of legislation. The AMA will provide information and assistance to these committees in dealing with health legislation in the state.

Mr. Cooper reported that the master contract for our new major medical insurance program had been approved, the brochure also approved and a mailing for this new insurance program should be sent out shortly. Our new group term life insurance program should be ready for mailing in November or December.

NEXT COUNCIL MEETING

The next meeting of the Council will be held on December 14 at the Ramada Inn in Jefferson City. The Budget Committee will meet at 2 PM at the Ramada Inn on Friday, December 13.

The meeting was adjourned.—**Referred to Reference Committee on Reports of Officers.**

Meeting of Dec. 14, 1974

■ Max S. Franklin, M.D., St. Louis, Chairman, called the meeting to order. Those present were Drs. Franklin; James C. Cope, Columbia; R. Allen Chandler, Kansas City; John I. Matthews, Jefferson City; Donald R. Judd, St. Louis; E. A. Stricker, St. James; John N. Martin, St. Joseph; Louis P. Hetlage, Troy; Robert E. Bregant, Jefferson City; William D. Bradshaw, Clinton; Andrew McCanse, Kansas City; Howard J. McAlhany, Springfield; Claude W. Cooper, Thayer; Eugene T. Hansbrough, Poplar Bluff; Stanley S. Peterson, Springfield; J. Loren Washburn, Versailles; Richardson K. Noback, Kansas City; George Thoma, St. Louis; Joseph White, William C. Allen and William D. Mayer, Columbia; Herbert R. Domke, Jefferson City; Charles Sherwin, St. Louis; Paul R. Young, Columbia; Mrs. George J. Lytton and Mrs. William R. McPhee, Kansas City; Messrs. James L. Hamilton and Timothy J. Danis, St. Louis; John F. Norwood and Robert Thebeau, St. Louis; Hollister S. Smith, St. Louis; Allen D. Smith, Kansas City; Ray McIntyre, Royal O. Cooper, C. C. Swarens, Ron Ellison and Don Wilson, Staff.

Special guest at the MSMA Annual Session was Frank J. Jirka, Jr., M.D., a member of the American Medical Association's Board of Trustees. Dr. Jirka addressed the House and was the featured speaker at the MSMA General Luncheon on April 19.

On motion, duly seconded, the minutes of the Sept. 14, 1974 Council Meeting were approved.

REPORT OF AD HOC COMMITTEE ON CME

Dr. Young stated that the Council had received a copy of the proposed *Accreditation Manual for Continuing Medical Education Activities in Missouri.* Dr. Young indicated that this program has been submitted to the AMA for approval. Basically, the program is a system which provides for accreditation for educational programs sponsored by hospitals, group practices, county medical societies, etc.

REPORT OF THE EXECUTIVE SECRETARY

Dr. Martin moved that the Council approve the continuing education program for implementation. Motion was seconded and carried.

Mr. McIntyre stated that at its December meeting, the AMA House of Delegates had approved a $60 assessment effective on Jan. 1, 1975 for all AMA members. This will be in addition to the current $110 AMA dues and will be billed directly to members from the AMA. This assessment is for one year. At its Annual Meeting in June in Atlantic City, the AMA House will consider whether or not to raise AMA dues.

Mr. McIntyre reported that the St. Louis Court of Appeals upheld the decision of the lower court in our favor in the suit against MSMA and the Health Care Foundation. The appellants have appealed to the St. Louis Court of Appeals for a rehearing or to the Supreme Court of Missouri. No decision has as yet been made in regard to the rehearing.

Mr. McIntyre stated that letters had been sent to the Commission and Committee Chairmen asking for their reports for the Handbook. Letters also have been sent to the presidents and secretaries of county societies asking for resolutions by the Speaker of the MSMA House of Delegates. Resolutions to be included in the Handbook should be in the MSMA office no later than March 1.

Mr. McIntyre reported that the MSMA Woman's Auxiliary is seeking tax exempt status. The charter for the Woman's Auxiliary will have to be expanded in certain objectives and specifications. Legal counsel is working on this matter.

REPORT OF BUDGET AND FINANCE COMMITTEE

The Budget and Finance Committee met on Friday afternoon, December 13, prior to the Council Meeting on Saturday. The Committee reviewed the material presented which showed Exhibit A—Actual Income through Oct. 31, 1974, Expected Total Income for 1974, Income Budget for 1974 and Estimated Receipts for 1975. Exhibit B—Actual Expenditures through Oct. 31, 1974, Estimated Expenditures for 1974, Budget for 1974 and Proposed Budget for 1975. Exhibit C—Actual Meeting and Committee Expenses through Oct. 31, 1974, Estimated Expenses for all of 1974, Budget for 1974 and Proposed Budget for 1975. A breakdown of anticipated income and expenses for the years 1974 and 1975 also was included.

The Budget and Finance Committee approved the following proposed budget for 1975:

Salaries	$169,198.00
Furniture and Fixtures	500.00
General Expense	4,550.00
Office Supplies	5,550.00
MSMF Assessment	41,000.00
Journal Expense	44,000.00
Postage	6,000.00
Equipment Rentals and Repairs	4,000.00
Telephone and Telegraph	8,600.00
Pension Expense	30,000.00
Legal and Professional	9,000.00
Payroll Taxes	8,655.00
Commission-Committee Meetings	51,800.00
Annual Session	23,000.00
Discretionary Council Fund	5,000.00
Taxes—I.R.S.	1,200.00
Travel Expenses	17,000.00
Building Expense	13,300.00
MMPAC Educational Projects	3,000.00
Improvements to Building	2,500.00
Total	$447,803.00

Dr. Judd, Chairman of the Budget Committee, reported that it was felt that there is a need to hold down the expenses of the AMA Delegates. Therefore, instead of paying all of the expenses for the AMA Delegates, the Budget Committee suggests to the Council that the AMA Delegates be furnished with airfare and a reasonable per diem. Dr. Judd indicated that he and Mr. McIntyre would come up with a suggested per diem. Motion was made, duly seconded and passed that the 1975 proposed Budget be approved.

1975 AMA CLINICAL SESSION

Mr. Cooper indicated that he had been in contact with Group Travel Unlimited in regard to group travel plans for the 1975 AMA Clinical Meeting in Hawaii. He said that there will be two separate departures from Kansas City and two from St. Louis. He stated that these travel plans need Council approval with additional details to be worked out.

It was moved by Dr. Hetlage to approve the travel plans for the 1975 AMA Clinical Meeting in Hawaii. Motion was seconded and carried.

REMARKS OF THE PRESIDENT

Dr. Cope stated that he had received a letter from a member in Columbia suggesting that a collection be taken up to help finance the way of the student delegates to the Annual Meeting. Dr. Cope indicated that he had suggested that this matter be run through the Boone County Medical Society.

Dr. Cope said that the MSMA had been given the opportunity to appoint a representative of MSMA to the Board of the Health Care Foundation PSRO Support Center. Dr. Clem Grebel of St. Louis has been appointed as our representative.

Dr. Cope reported briefly on a number of medical meetings he had attended since the last Council Meeting including Clinical AMA.

REPORTS OF DISTRICT COUNCILORS

District #1—Dr. Martin voiced his displeasure with some of the changes currently taking place within the AMA.

District #3—Dr. Franklin reported that the installation of officers of the St. Louis Medical Society will be held on January 7. Dr. August W. Geise, Jr. will be installed as President and Dr. James Stokes will be installed as President-Elect. Dr. Franklin extended an invitation to all present to attend this affair.

District #4—Dr. Hetlage stated that his district favored the certification of physician assistants and that this be done by the State Board of Registration for the Healing Arts. The law should contain provisions regarding training and provide for some control of the physician using such an assistant.

The Fourth District expressed concern that the AMA was proposing to no longer seek advertising and recommends that the MSMA does not follow suit.

Dr. Hetlage stated that his district feels that the local PSRO Foundation should make determinations on post admission certification of Medicaid patients.

Dr. Hetlage said the Fourth Councilor District would like to recommend to the AMA Delegation that they take opposition to the SSA Regulation regarding certification within 48 hours and scheduled to go into effect on Feb. 1, 1975. It was pointed out that no one is ready to implement this regulation on February 1.

Motion was made, duly seconded and adopted that county medical societies, hospital associations and local PSRO groups be asked to communicate with HEW expressing opposition to implementation of the regulation on February 1, since none of the groups feel prepared at this time.

Dr. Hetlage indicated that CEMPROC is alive and well. He reported that the Fourth District felt that the Health Care Foundation has gone off in a mistaken direction and is attempting in some way to supercede MSMA as a central representative organization. The Health Care Foundation is proposing to offer various programs that are presently being offered by MSMA.

Dr. Hetlage directed the Council's attention to the Buckley Amendment. This amendment permits or demands the divulgence of previously privileged information to the individual concerned. He indicated that, possibly, a patient now could demand access to his medical records. He stated that he would like for this to be referred to a Commission or Committee for study.

Dr. Noback stated that it is UMKC's understanding that this applied only to Medical Schools.

Dr. Franklin indicated that this matter would be referred to the Commission on Continuing Education and Health Manpower for study.

Dr. Hetlage stated that the St. Louis County Health Department Drug Abuse Program is not utilizing M.D.'s in their program.

He stated that this fall, St. Louis County had sponsored a county medical society officers meeting and that all present at this meeting felt that it was valuable. He said that he would like the Council to authorize a yearly meeting of this nature at no expense to MSMA.

Dr. Hetlage indicated that it was felt that due to the discontinuance of the AMPAC Workshops held in Washington each year, that the MSMA should consider sending a delegation to Washington yearly for a political briefing and to contact our Congressional Delegation.

District #5—Dr. Bregant indicated that he had no report at this time.

District #6—Dr. Bradshaw stated that all is well in his district.

District #7—Dr. McCanse reported that the Jackson County Annual President's Dinner will be held on January 10 and everyone is invited.

Dr. Malcolm Todd, the President of the AMA, will be in Kansas City on January 28 and 29 to address the first graduating class of the Mid-America Regional Council, Emergency Rescue Paramedics. A special meeting of the Jackson County Medical Society will be held to honor Dr. Todd on January 28. Everyone is invited to attend this function.

Dr. McCanse stated that Dr. Don Blim is the new President-Elect of Jackson County Medical Society and that the new medical school in Kansas City was dedicated on October 27. Jackson County will be implementing a TEL-MED System, and a continuing education committee has been appointed. There is concern in Jackson County about the current malpractice situation and there also is concern about the confidentiality of medical audit committee reports. Dr. McCanse stated that there is currently a program being carried out by medical students that, perhaps, has some ethical considerations. The students go into physicians' offices and leave forms and brochures describing an emergency medical service card that can be obtained by patients. The students are receiving some profit from the sale of these cards.

District #8—Dr. McAlhany stated that he had no report at this time.

District #9—Dr. Cooper stated that he had no report at this time.

District #10—Dr. Hansbrough stated that people are upset with the AMA assessment and the manner in which it is to be handled. He indicated that perhaps we should inform the AMA of this.

Dr. Hansbrough indicated that there is concern in his area over the Hospital Discharge Data Program. The SEMO Foundation is conducting continuing education programs and will be applying for certifications of their continuing medical education programs under the MSMA's new program.—**Referred to Reference Committee on Reports of Officers.**

GROUP PROFESSIONAL LIABILITY INSURANCE

■ Mr. James Hamilton of Rollins Burdick Hunter outlined for the Council their continuing efforts to obtain underwriters for a professional liability insurance program in Missouri. There have been some problems in the market place for malpractice insurance. Mr. Hamilton stated that, at this time, the program for the MSMA is 45% complete. He indicated that he would like to obtain from the Council another 90 days to complete the program for Missouri. Mr. Hamilton reported that he had arranged with Hartford and Lloyd's of London to take applications for malpractice insurance from physicians who are having problems obtaining it. This is to be done until such time as the MSMA has a program ready for its members.

Motion was made, duly seconded and adopted to give Rollins Burdick Hunter another 90 days to complete a professional liability insurance program to be sponsored by MSMA.—**Referred to Reference Committee on Constitution and Bylaws.**

REPORT OF COMMISSION ON PUBLIC AFFAIRS

■ The Commission on Public Affairs met on September 29 and submitted the following report to the Council.

The Commission voted against recommending a Public Affairs Conference for 1975. Despite excellent programs, attendance has been poor—mostly captive. As a replacement, the Commission recommends:

(A) Encourage physicians to appear before local clubs and organizations to tell medicine's story.

(B) Stimulate a Speaker's Bureau in areas in which they are not now functioning and have present Speaker's Bureau do more. Identify speakers who are capable and willing to serve.

(C) That the Association continue to sponsor specialized meetings which answer specific needs to members and prospective members—i.e., Management Workshops, Public Speaking Programs, etc.

The Commission also discussed the problem areas of physician distribution. It is hoped the various groups looking into this matter will concentrate more heavily on finding ways to stimulate self-sustaining groups to locate in rural areas rather than pinpoint individual physicians.

The following two motions were adopted by the Commission:

(1) "The MSMA should reevaluate the distribution of medical service in Missouri and reconsider the physicians' assistant's role in medical care."

(2) "The Commission feels that the MSMA should request all the medical schools in Missouri to consider assisting in alleviating the maldistribution of physicians training, by encouraging the preceptorship or similar programs and by investigating the possible advantages of expanded training for physician assistants."

In the area of communications, the Commission intends to delve further into the area of public information by telephone. We discussed the highly successful TEL-MED system, but felt that the high costs for a state-level operation would be prohibitive.

The Commission hopes that some of the larger component societies will research the possibility of gaining grant funds to operate TEL-MED or similar projects on a local basis.

The Commission discussed and rejected the possibility of publishing "tent cards" in Missouri Medicine. These cards would have been detachable and could be placed in physicians offices.

The Commission considered the Division of Health's concern regarding the present venereal disease outbreaks in the metropolitan areas and instructed staff to prepare an article for the Journal. Since the Division of Health expressed concern over the fact that physicians are not reporting cases of venereal disease, it was asked that the article stress that confidentiality will be safeguarded.

Dr. Allen Klippel presented an update on progress made in the field of emergency medical services since the passage of SB 57, *the Ambulance Bill.* Despite problems which are bound to arise in implementing any new legislation, it appears that SB 57 is serving to improve emergency medical care in Missouri by providing for better vehicles and expanded training for ambulance personnel.

The Commission enjoyed the presence and participation of Ed Burns, a medical student at the University of Missouri School of Medicine, during its meeting. Mr. Burns requested the Commission's endorsement of a grant study proposal to be submitted to HEW.

The study calls for development of evaluative criteria for emergency medical services in hospitals. Groups in various parts of the state will try to develop methods which they believe will provide for effective evaluation of hospitals in their area. A composite of these reports will then be molded into one report.

The overall purpose of the project is to provide guidelines whereby hospitals can more effectively set up their emergency medical service in cooperation and coordination with other hospitals in the area.

This project would be carried out by the Section of Behavioral Sciences of the Department of Community Health and Medical Practice at the University of Missouri-Columbia Medical School.

Mr. Burns specifically requested the endorsement of the Commission and it was granted. The Commission recommends that the Council also support this.

The two motions adopted by the Commission were discussed and were accepted as information as there are various groups studying this problem.

Motion was made, duly seconded and adopted to accept the report of the Commission on Public Affairs.—**Referred to Reference Committee on Miscellaneous Affairs.**

REPORT OF THE MSMA FIELD SECRETARY

■ Mr. Don Wilson reported that in approximately two months of field work, he had made initial contact in all ten districts. He stated that he had talked with officers and members in 32 of the 49 societies. He stated that physicians have been seemingly pleased and, in some cases, surprised that the State Association has someone to call upon them in their offices. Talks with physicians have covered a wide variety of subjects and matters of concern.

Dr. Hetlage expressed his approval and appreciation for what Mr. Wilson has done in his District and asked Mr. Wilson if he felt a second field secretary was necessary. Mr. Wilson indicated that in some cases, he had only talked with the President and Secretary of the Society, but had also attended a fair number of medical society meetings.—**Referred to Reference Committee on Reports of Officers.**

REPORT OF THE COMMITTEE ON CONSTITUTION AND BYLAWS

■ The Committee on Constitution and Bylaws met on November 25 and submitted the following recommendations to the Council:

Recommendation #1—It is recommended that the MSMA Council adopt their own mechanism to provide for someone to represent the Councilor District in the absence of the elected Councilor. The Committee recommends that if a Council knows he will be unable to attend a meeting, he may be allowed to designate a physician from his district to represent him during the Council meeting. This designated representative could discuss and present the views of the Council District on all issues, but would not have the right to vote. This designated representative could then meet and discuss the activities of the Council meeting with the Councilor.

Motion was made by Dr. McAlhany that Recommendation #1 be accepted. Motion was duly seconded and carried.

Recommendation #2—If Resolution #40 providing for Unified Membership with the AMA is adopted at the first session of the House of Delegates at the 1975 Annual Meeting, we suggest the following necessary changes in the Constitution and Bylaws:

1. Amend the Constitution of the Missouri State Medical Association by striking out "Article III. Membership" and inserting in lieu thereof the following:

"Membership in this Association shall be limited to and include all members in good standing in component societies which hold charters from this Association and who are members in good standing of the American Medical Association."

2. Amend the Bylaws of the Missouri State Medical Association as follows: Amend "Chapter I. Membership" by striking out all of Section 1 of Chapter I and inserting in lieu thereof the following:

"Section 1. Members of this Association shall be physicians whose names have been certified by secretaries of component societies to the Secretary of this Association that they are duly elected members of a component society and are legally qualified physicians practicing in Missouri and are members of the American Medical Association except as otherwise provided. Each member must be of good moral and professional standing, and must not support, nor practice, nor claim to practice any exclusive system of medicine."

3. Amend Chapter VIII, Section 1(a) of the Bylaws by striking out Section 1(a) of Chapter VIII and inserting in lieu thereof the following:

"Section 1. (a) The annual dues of this Association shall be $90.00, which shall be applicable to each active member of the Association beginning in 1975 and shall be levied per capita on the active members of the component societies; the per capita levy for junior members shall be $10.00 per year; honor and associate members shall not be required to pay dues. Dues shall be payable on January 1 of the year for which they are levied. Any forgiveness of the dues and assessments of the AMA shall be in accordance with rules and regulations of that Association."

4. Amend Chapter VIII, Section 4, of the Bylaws by striking out Section 4 of Chapter VIII and inserting in lieu thereof the following:

"Section 4. The Secretary of each component society shall cause to be collected and remitted to the Treasurer of this Association the dues and capita levies of this Association and the dues and assessments of the American Medical Association. Any member whose name has not been reported for enrollment and whose dues, capita levies of this Association and dues and assessments of the American Medical Association have not been remitted to the Treasurer of this Association on or before March 1 of each year shall stand suspended until his name is properly reported and his dues, capita levies and assessments for the current year are paid. On December 31 of each year, members delinquent in payment of such dues and assessments, or any part thereof shall, ipso facto, forfeit their memberships. No suspended member shall be eligible to register at an annual session."

Motion was made, duly seconded and adopted to accept Recommendation #2 as information.

Recommendation #3—Resolution 5—MSMA Parliamentary Procedure—It is recommended that Resolution 5 introduced in the 1974 House of Delegates be re-referred to a Reference Committee during the 1975 Annual Session. If after hearing testimony in support of this resolution the Reference Committee recommends adoption of Sturgis Standard Code of Parliamentary Procedure in lieu of Roberts Rules of Order and if the House of Delegates adopts the recommendations of the Reference Committee, the Committee on Constitution and Bylaws recommends the following change in the Bylaws:

"Chapter X. Rules of Order. The deliberations of this Association shall be conducted in accordance with parliamentary usage as defined in Sturgis Standard Code of Parliamentary Procedure."

Motion was made by Dr. Hansbrough that Recommendation #3 be accepted and supported. Motion was seconded and adopted.

Motion was made, duly seconded and adopted to accept the report as a whole.—**Referred to Reference Committee on Constitution and Bylaws.**

REPORT OF THE COMMITTEE ON VOLUNTARY HEALTH AGENCIES

■ Dr. William Allen, Chairman of the Committee, stated that a list of Voluntary Health Agencies in Missouri had been published in the July 15 issue of Missouri Medicine.

It was recommended that if each organization listed would be willing to supply funds, that the list published in the July 15, 1975 issue be expanded to include a summary of the purpose, size and type of membership and current activities of each of the organizations listed. Copies of the list would be made available to the Osteopathic Association for distribution to their members.

The Committee also recommended that a meeting of the Committee on Voluntary Health Agencies with representatives of the voluntary health organizations is of sufficient value that it should be continued on an annual basis. It was reported that an estimate of the cost of printing 10,000 copies of the list of voluntary health agencies as outlined above would be $1,500. Dr. Allen stated that if the Council gives approval to the above recommendation, the various voluntary health agencies would be contacted to see if they would be willing to provide funds.

Motion was made by Dr. Hansbrough to accept the report and the recommendation. Motion was seconded and adopted.—**Referred to Reference Committee on Medical Education and Public Welfare.**

REPORT OF AMA DELEGATES

■ Dr. Peterson stated that quite a lot of things had been done during the AMA Clinical Session in Portland. A special assessment of $60 for a one-year period for AMA members was approved and is effective on Jan. 1, 1975. This was designed to remedy the immediate financial needs of the AMA. A special committee was set up to study the question of a dues increase along with the AMA's financial situation and will report back at the 1975 Annual Meeting.

Dr. Peterson stated that Dr. Malcolm Todd, President of the AMA, had given the best speech of any AMA President that he had heard and he felt that it should be printed either in part or whole as a special article in the Journal.

The House urged the Board of Trustees to restore the structure of several councils and committees and maintain present publication for several AMA publications. The House also approved advertising as a legitimate function in AMA publications.

The House adopted several recommendations in regard to house staffs. It also adopted a report calling for strong programs of continuing medical education and peer review as alternatives to relicensure. The AMA adopted a report containing basic guidelines for NHI deliberations. The AMA House adopted a resolution expressing opposition to U. S. House of Representatives' manpower and planning bills.

A new policy stating that acupuncture should be performed only in research settings by a physician or under the direct supervision of a physician was adopted. A Judicial Council report was adopted which states, "It is not unethical for a physician to authorize the listing of his name and practice in a (community) directory for professional or lay use which is intended to list all physicians in the community on a uniform and nondiscriminatory basis. The listing shall not include any self-aggrandizing statement or qualitative judgment regarding the physician's skills of competence."

Dr. Peterson reported that the disapproval of the special assessment by doctors at large had been recorded three different times during the meeting. The whole financial situation of the AMA had only been called to the attention of everyone approximately three weeks before the meeting and there was really no time to consider any reasonable recommendations and no time for the Delegates to discuss this with their constituents. The entire matter will be brought up at the 1975 Annual Meeting for consideration.

Dr. Peterson stated that doctors should recognize that the AMA is the best organization that doctors have to represent them and we should do everything we can to preserve the AMA.

Motion was made, seconded and carried to approve the AMA Delegate report.

REPORT OF THE WOMAN'S AUXILIARY

Mrs. Lytton passed out copies of the *Missouri Doctor's Wife*, the publication of the MSMA Woman's Auxiliary, and indicated that this is a very fine publication.

The Woman's Auxiliary held its Fall Conference in Springfield in October and had a very good attendance. The program consisted of a panel on aging, presentation on solid waste from the EPA and an excellent presentation on legislation by Dr. Jack Matthews. The Auxiliary gave a donation to the MSMF in Dr. Matthews' name for his excellent participation.

The Environmental Protection Agency has contacted the Woman's Auxiliary as resource people for the advancement of the solid waste program in Missouri. The Auxiliary members will give their services and Mrs. Lytton indicated that they will be willing to help with other programs that the Council feels needs their assistance.

Mrs. Lytton said that she has been doing considerable traveling and stated that she is happy to visit any county which requests. She thanked the Council for their backing of Auxiliary activities.—**Referred to Reference Committee on Reports of Officers.**

HR 16204—HEALTH PLANNING BILL

■ Dr. William Mayer, member of the Executive Committee of the Regional Advisory Group of MRMP and as chairman of MRMP's Transition Committee, gave a presentation regarding HR 16204. This involves the transition of existing separate federal legislation regarding CHP, RMP and Hill-Burton programs to single legislation called the National Health Planning and Development and Health Facilities Assistance Act of 1974. This transition Committee was set up to keep track of the developments of this legislation. MRMP felt that it might be worthwhile to share the knowledge of these developments with MSMA.

Dr. Mayer reported that although the precise format of this legislation is unclear, there is a likelihood that this will become a new law by the time the 93rd Congress adjourns. The Senate passed S.B. 2994 on November 26 and late on December 13, the House passed HR 16204. The Conference Committee is working hard to get this bill out. It is likely that the President will sign it.

Dr. Mayer gave several quotes from the Committee on Labor and Public Welfare Report on November 12, which indicated that a majority of the members of governing bodies of health planning agencies be consumers of health services; that if the plan which emerges is to be viable, the providers of health services influence on the health planning process must be appropriately limited. Dr. Mayer reviewed

Dr. Eugene T. Hansbrough *(left)*, who was reelected as Councilor for the Tenth MSMA District, congratulates Dr. Robert Slickman, who was elected as a Delegate to the AMA in St. Louis.

the nature of the legislation. Although many details are unclear, it establishes three entities: (1) Health Service Areas within states; (2) Statewide Health Coordinating Councils; (3) National Council for Health Policy. It is unclear as to the size of these health agencies. The House version stipulates that the Health Service Areas (HSA's) should be representing populations of one-half million to three million; 200,000 in unusual circumstances and less than 200,000 in very unusual circumstances. The designation of HSA's is left to the Governor. The Senate version does not stipulate size but probably would be the existing "B" Agencies. The HSA's would be the main responsible group for health planning within the state. The functions of the HSA's is slightly unclear and still under some debate. Functions might include planning; review and approval of grants and contracts under numerous federal programs; review and recommendations regarding new institutional health services, health care facilities, HMO's, etc. within HSA. Statewide Health Coordinating Council—the Governor has the authority to designate the state agency responsible.

Dr. Mayer said that he did not feel the functions under this particular bill were really the most important issue, but it lays out a structure which could be of vital importance in the future. The Governor designates the HSA's and the Governor develops mechanisms for designating Health Systems Agencies. He indicated that he felt it is very critical that MSMA keep close tabs on these items. He feels that the providers of health services in this state may have some meaningful comments to make relative to the provision of health services.

Dr. Mayer closed by saying that the Transition Committee of MRMP and the Executive Committee will continue to monitor the developments rather closely and will contact MSMA when there are developments of potential importance.—**Referred to Reference Committee on Miscellaneous Affairs.**

HOSPITAL DISCHARGE DATA PROGRAM

■ Dr. Charles Sherwin, St. Louis, accompanied by Mr. John Norwood, Administrator of Bethesda Hospital and Mr. Robert Thebeau, Assistant Executive Director of St. Mary's Health Center, read a proposed resolution opposing the Proposed Uniform Hospital Discharge Data Program of the Division of Health.

It was reported that the scheduled mandatory reporting system set to take effect on January 1 will continue to be voluntary as was the case in the past with the "Icepick Program."

Much discussion followed by Messrs. Thebeau and Norwood as to their concern regarding revealing of confidential information and the cost of securing this information. Dr. Domke spoke on behalf of the Board of Health and the necessity for securing such information, stating that patient confidentiality would definitely be upheld.

Dr. Sherwin stated that in view of the rescinding of the mandatory provisions, he would submit his resolution to the MSMA House of Delegates at the upcoming Annual Session with some revisions.—**Referred to Reference Committee on Medical Education and Public Welfare.**

REPORT OF THE DEANS

■ Dr. Joseph White, Acting Dean, University of Missouri-Columbia, reported that they have appointed a new Chairman of the Department of Surgery.

Dr. White reported on a method for providing financial support for medical students by a community if the medical student agrees to serve that community for a given period of time. He stated that the University is not involved in this and they do not support it, but wanted to call the Council's attention to it.

Regarding progress of admissions, Dr. White stated that instate applications are down about 100 and out-of-state applications are down about 40%. They still have about the same number of highly qualified applicants from whom to select.

Dr. White reported on the investigation of admissions procedures which took place by a special committee of the Missouri House of Representatives. The Committee asked that the number of students be increased. Dr. White stated that there are two state schools, two private schools and two osteopathic schools; the problem is that not enough students elect to stay and practice in the state of Missouri.

Dr. White reported on several items regarding family practice residents, percentages of money received from the federal government, etc.

Dr. George Thoma, St. Louis University, reported on several appointments recently made by the St. Louis U. Medical Center, including the hiring of a Dean for the Medical School.

Regarding last year's admissions, Dr. Thoma reported that 50% of the class were Missourians and 23% women. These made a grade point average of 3.56. St. Louis University Medical Center is establishing a new Division of Forensic Pathology.

Dr. Richardson K. Noback, Dean of the University of Missouri-Kansas City Medical School, reported that out of 72 new freshmen brought in last fall, only one is in real jeopardy. The University has acquired a new Chairman of the Department of Pathology.

The University of Missouri-Kansas City School of Medicine was dedicated on October 27 and is in use. Truman Medical Center is to be completed by August, 1976. Dr. Noback named several other appointments recently made at the school. He said that the preceptorship program with the Academy of General Practice is in good order.—**Referred to Reference Committee on Reports of Officers.**

LEGISLATIVE REPORT

■ Dr. Matthews discussed the activities of the Legislative Interim Health Committee which included hearings on Surgicenters, Physician Assistants, Acupuncture and Medical Laboratories. To date, a bill has been prefiled to allow establishment of surgicenters. Bills in the other three areas have not yet surfaced.

Dr. Matthews informed the Council that the County Medical Examiner System, passed by the 77th General Assembly, has been declared invalid by the St. Louis Circuit Court. Two new bills to reestablish the validity of the Examiner System have been prefiled and will again receive the support of MSMA.

The proposed new Nurses Practice Act, which has been prefiled, also was discussed and no objections to the bill as written were voiced.

In the area of confidentiality of medical information, two state senators have indicated that they plan to prefile measures which will insure confidentiality.

Other matters brought up in the report include prefiled bills on fluoridation; establishment of joint legislative Committee on Health Affairs, establishment of a program for prevention and control of alcohol, several measures dealing with highway safety and numerous health and accident insurance bills.

A brief discussion followed regarding legislative matters. On motion, duly seconded, the report of the Committee on Legislation was accepted. Motion carried.—**Referred to Reference Committee on Miscellaneous Affairs.**

DIRECTOR, MISSOURI DIVISION OF HEALTH

■ Dr. Domke, Director of the Missouri Division of Health, reported that there has been an epidemic of infectious syphilis for the past 15 months in the state of Missouri. He indicated that they are getting excellent technical performance, but cannot seem to get the epidemic under control. He indicated that there must be a change in attitude of the private physician in reporting the cases he sees. It is absolutely imperative that physicians report all cases of venereal diseases which they see in their private office.

Dr. Domke reported that they have delivered 41 fully equipped ambulances since July 1 and there are 43 more on order right now. There are presently 50 ambulance districts in the state.

117TH MSMA ANNUAL SESSION

Mr. Ellison reported that planning for the 117th Annual Session is going along on schedule. Of those specialties which have indicated they will sponsor programs, about one half have sent in their detailed programs. The program will be published in Missouri Medicine each month beginning with the January issue until the time of the Annual Session. Mr. Ellison asked the Councilors to please inform the MSMA Headquarters office if they plan to hold a breakfast for their delegations. The Annual Meeting will be held at the Chase-Park Plaza Hotel in St. Louis on April 17-20, 1975.—**Referred to Reference Committee on Medical Education and Public Welfare.**

MSMA MALPRACTICE INSURANCE

■ Mr. McIntyre indicated that Mr. Cooper has been working very closely with Mr. Hamilton and Rollins Burdick Hunter Company regarding MSMA malpractice insurance. He stated that the papers had been signed recently to set up a corporation when and if the program becomes effective. There will have to be a board set up to operate the corporation and there will have to be funds set aside. The Board for the corporation would consist of five Directors—two from MSMA. It was agreed that the President should designate the two MSMA members to the Board of Directors.—**Referred to Reference Committee on Constitution and Bylaws.**

Newly-elected Treasurer Richard V. Bradley visits with Vice-Speaker James T. Brown, who was elected Speaker during the Annual Session.

NEXT COUNCIL MEETING

■ The next meeting of the MSMA Council will be held on Saturday, February 8 at the Ramada Inn in Jefferson City. There will be an Executive Meeting of the Council on Friday evening, February 7, at 5 PM followed by dinner.

The meeting adjourned at 4:30 PM.—**Referred to Reference Committee on Reports of Officers.**

Meeting of Feb. 8, 1975

■ Max S. Franklin, M.D., St. Louis, Chairman, called the meeting to order. Those present were Drs. Franklin; James C. Cope, Columbia; R. Allen Chandler, Kansas City; John I. Matthews, Jefferson City; Donald R. Judd, St. Louis; E. A. Stricker, St. James; John N. Martin, St. Joseph; Louis P. Hetlage, Troy; Robert E. Bregant, Jefferson City; William D. Bradshaw, Clinton; Andrew McCanse, Kansas City; Howard J. McAlhany, Springfield; Claude W. Cooper, Thayer; Eugene T. Hansbrough, Poplar Bluff; Rae W. Froelich, Lebanon; Hubert A. Ritter, St. Louis; George Thoma, St. Louis; William C. Allen, Columbia; Richardson K. Noback, Kansas City; Herbert R. Domke, Jefferson City; Clement B. Grebel, St. Louis; Mr. James Hamilton, St. Louis; Mr. E. Mark Halvorson, Jefferson City; Mrs. George J. Lytton and Mrs. William R. McPhee, Kansas City; Messrs. Hollister S. Smith, St. Louis; Allen D. Smith, Kansas City; Gary L. Schnedler, Springfield; Ray McIntyre, Royal O. Cooper, C. C. Swarens, Ron Ellison and Don Wilson, Jefferson City, Staff.

MSMA-SPONSORED MEDICAL MALPRACTICE INSURANCE PROGRAM

Mr. James Hamilton of Rollins Burdick Hunter brought the Council up to date on what had taken place in the malpractice insurance market place since the December Council Meeting. He stated that the National Association of Insurance Commissioners had set up a specialty committee on malpractice insurance. The committee has had meetings and will make specific recommendations to the Secretary of HEW on February 19, as to how the malpractice insurance problem in this country could be solved. He pointed out that two bills had been introduced in the U. S. Senate in regard to the malpractice situation.

Mr. Hamilton reported that incorporation papers had been filed for Missouri State Medical Insurance, Inc. Bylaws and Articles of Incorporation have been written and are being studied by the MSMA legal counsel and the legal counsel for RBH for their comments and suggestions.

There has been one definite offer from an insurance carrier to provide malpractice insurance for MSMA members. It is hoped that there will be several more. The members of the Board of MSMI will meet on February 22. It is hoped that by March 1, a decision will be made as to what carrier or carriers will be chosen to provide malpractice insurance for members. This program should then be in operation on or before April 17.

Motion was made, seconded and adopted that a glossary of insurance terms be provided for MSMA by Rollins Burdick Hunter.

APPROVAL OF MINUTES

On motion, duly seconded, the minutes of the Dec. 14, 1975 Council Meeting were approved.

COUNCILOR DISTRICT REPORTS

District #10—Dr. Hansbrough reported that President Cope had attended the SEMO Cancer meeting in Poplar Bluff on February 2 and had given an excellent talk. Dr. Hansbrough stated that he would like to see Dr. Cope's speech published in MISSOURI MEDICINE.

Dr. Hansbrough reported that there is a problem concerning malpractice insurance in his district but after receiving a report from Mr. Hamilton, he would have something to report to the doctors in his area.

District #9—Dr. Cooper stated that the primary interest in his area is in the malpractice insurance problem and that he would now have something to tell them.

District #8—Dr. McAlhany stated that doctors in his area had increases in their malpractice insurance premiums and that in some cases, the doctors were asked to write letters to the insurance companies agreeing to the increase. Dr. McAlhany stated that it seemed to him that medical malpractice insurance is only one aspect of a very broad spectrum. He stated that he hoped the Council would consider the following steps, working with the Staff and the Legislative Committee to stabilize the professional liability insurance market in Missouri:

1. Introduce legislation requiring uniform, graduated schedules of contingent fees in all malpractice cases.
2. Introduce legislation requiring mandatory arbitration for resolution of malpractice decisions.
3. Introduce legislation to put a ceiling on malpractice awards.
4. Consider placing malpractice insurance under a state program similar to Workmen's Compensation laws.

On motion, duly seconded, the four steps listed above were approved by the Council.

District #7—Dr. McCanse reported that Dr. and Mrs. Cope and Mr. and Mrs. McIntyre had attended Jackson County's Annual President's Dinner on January 10. Dr. Malcolm Todd of the AMA attended and spoke at a dinner in Kansas City on January 28.

Dr. McCanse stated that the area medical council had met with representatives of the Attorney General's office and the Federal Trade Commission. As a result of those meetings, the weight reduction clinics in Kansas City had closed.

Jackson County's Tel-Med program has been implemented. This is a five day a week, eight hour a day service. It consists of 200 tapes approved by the Medical Society which provide information to laymen on different disease states.

Dr. McCanse indicated that there also is concern in his area on the malpractice situation. He stated that he was happy to hear that MSMA is close to establishing its own program for members.

District #6—Dr. Bradshaw stated that there will be a meeting of the Sixth Councilor District on February 27, and Dr. Cope will attend. The meeting will consist of four workshops. He said he hoped that the doctors' wives would participate, also.

District #5—Dr. Bregant indicated that he did not have a report at this time.

District #4—Dr. Hetlage reported that Mr. James Hamilton of Rollins Burdick Hunter had met with those present at his Fourth Councilor District Conference and had presented an update on the status of the proposed MSMA-sponsored malpractice insurance plan. Dr. Hetlage stated that the Fourth Councilor District had come up with four suggestions in regard to the malpractice program that are similar to those presented by Dr. McAlhany.

Hospital post-admission certification regulations proposed by the SSA to be implemented on February 1 were discussed at the Fourth District meeting. During that meeting, it was pointed out that hospitals had been granted a 90-day extension to activate such regulations.—**Referred to Reference Committee on Constitution and Bylaws.**

■ Discussion at the Fourth District meeting also concerned physicians unions and uniform insurance forms. A discussion was held relating to Blue Shield summary payment procedures, and it is recommended that further negotiations be held with Blue Shield to permit a summary billing form in lieu of individual forms. Dr. Hetlage stated that he would suggest that the summary billing form be referred to the Commission on Medical Economics for study.—**Referred to Reference Committee on Resolutions.**

■ Dr. Hetlage reported that there was concern over the various ramifications of the Health Planning and Resources Development Act. Concern was expressed on House Bill #1211, which was passed during the last session of the General Assembly and which sets the principles for reporting of abortions to the Division of Health.—**Referred to Reference Committee on Medical Education and Public Welfare.**

■ Dr. Hetlage stated that the Fourth Councilor District still favored a change in the Constitution and Bylaws which would officially designate an elected vice-councilor. A recent report of the Constitution and Bylaws Committee suggested that each district appoint rather than elect a vice-councilor, the latter requiring a change in the Constitution and Bylaws.—**Referred to Reference Committee on Constitution and Bylaws.**

■ Dr. Hetlage stated that he felt that some of the commissions did not meet as often as they should. He also stated that since the AMPAC workshop in Washington has been discontinued, MSMA should arrange a trip to Washington in order to make contact with our Congressional delegation.

Mr. McIntyre indicated that previously we had some contact with the Governor's Office in regard to the Health Planning and Resources Development Act. At that time, we expressed an interest in having a representative on a task force or committee that would implement this law if the bill were passed by Congress.

District #3—Dr. Franklin reported that the St. Louis Medical Society would have a party on April 17 for all delegates and their wives attending the MSMA Annual Meeting.

Dr. Franklin stated that he and others had received a pamphlet from Washington University outlining abortion services provided by them. He indicated that he felt that this was a breach of medical ethics in that it constituted the solicitation of patients.

Dr. Hetlage stated that, perhaps, a letter should be sent to Washington University reminding them of this principle of medical ethics.

Motion was made, duly seconded and adopted to send a letter to Washington University reminding them that advertising and solicitation of patients is unethical.

It was stated that, perhaps, the other medical schools in the state should be contacted and reminded of this principle of medical ethics.

District #1—Dr. Martin stated that many doctors in his District were not renewing membership in the AMA.—**Referred to Reference Committee on Medical Education and Public Welfare.**

HCFM/PSRO SUPPORT CENTER

■ Dr. Grebel reported that the Constitution and Bylaws and Articles of Incorporation of the HCFM/PSRO Support Center had been changed and had been filed and approved by the Secretary of State. The new Board consists of three physicians from each of the five areas plus a representative from the MSMA and the Osteopathic Association. He indicated that all five PSRO areas have good interface with the Secretary of HEW. Funding for the PSRO Support Center is on a contract basis rather than a grant basis.

Dr. Grebel stated that once the five individual PSRO's are operating, there may be no justification for funding a Support Center. He stated that under PL92-603, there was no description of a support center. However, the law does state that in states that have three or more PSRO's, there would be a State Professional Review Council. Perhaps, HCFM could serve in an advisory capacity and expedite the role of this State Council.

Dr. Grebel stated that the Secretary of State had on his desk a plan calling for an Association of Missouri Peer Review Organizations (AMPRO). This organization is on paper only.

This organization would not come into being unless requested to do so by the five area PSRO's. It would be a service organization to meet the needs of the private sector of medicine and to offer a variety of physician services.

Dr. Grebel expressed his high regard for the executives of the five PSRO areas. He reported that a monthly newsletter containing material submitted by each of the five areas had recently been instituted. The HCFM/PSRO Support Center is one of three cosponsors of a discussion on quality assurance that will be held on March 7 at the University of Missouri School of Medicine-Columbia.

Dr. Grebel reported the HCFM/PSRO Support Center had rented an exhibit booth at the MSMA Annual Convention and representatives of each of the five areas will be there to hand out material and answer questions that physicians may have.

Mr. McIntyre asked that before any action is taken on AMPRO, the matter be brought before the Council for discussion and action. Dr. Grebel said that this would be done.

Dr. McAlhany moved the acceptance of Dr. Grebel's report. Motion was seconded and adopted.—**Referred to Reference Committee on Resolutions.**

REPORT OF THE TREASURER

■ Dr. Judd reported that a copy of the audited 1974 MSMA financial statement had been received. The statement shows a smaller deficit than had previously been anticipated. The Financial Statement will be published in the March issue of MISSOURI MEDICINE.

REPORT OF THE PRESIDENT

President Cope stated that a Dr. Moser, a dentist from New Franklin, Mo., will be 100 years old on March 7 and he would like permission to send a letter of congratulations to Dr. Moser.

Dr. Cope reported that he had received a letter from President Ratchford of the University of Missouri asking MSMA to submit a name of a representative for his Committee on Education for the Health Related Professions. Dr. Gerald Miller presently serves on this committee. Dr. Cope indicated that a letter should be sent to Dr. Miller asking him whether or not he would like to continue to serve on this committee.—**Referred to Reference Committee on Reports of Officers.**

■ Dr. Cope stated that an excellent article on the malpractice situation in the *St. Louis Globe-Democrat* had been written by Mr. Lon Hocker, an attorney. Dr. Cope stated that he felt a letter should be sent to Mr. Hocker thanking him for his thoughts on the malpractice problem. Dr. Ritter stated that he had sent a copy of Mr. Hocker's editorial to the *AMA News*.

Dr. Cope stated that he had a suggestion in regard to the malpractice insurance problem. He stated the feasibility of "Airport-type" insurance that can be purchased from machines should be looked into as a means of securing malpractice insurance.

Motion was made, seconded and adopted to refer this matter to the Commission on Medical-Legal Affairs.—**Referred to Reference Committee on Constitution and Bylaws.**

REPORT OF THE EXECUTIVE SECRETARY

■ Mr. McIntyre reported that Dr. Slickman, Speaker of the House of Delegates, could not be present at this meeting. He stated that Dr. Slickman would appreciate receiving from Councilors the names of Delegates from their districts who they would like to have serve on Reference Committees.

Mr. McIntyre reported that motions for a rehearing or transfer to the Supreme Court which had been made by the plaintiffs in the Health Care Foundation suit had been denied. The matter is now closed.

Dr. Hetlage stated that he would like to obtain the total cost in legal fees that had been spent by MSMA in regard to this suit.

Mr. McIntyre reported that since the last Council meeting, he and Mrs. McIntyre and Dr. and Mrs. Cope had attended the installation meetings of the St. Louis Medical Society, Jackson County Medical Society, St. Louis County Medical Society and Greene County Medical Society. At the St. Louis Medical Society installation dinner, Mr. Hollister Smith, Executive Secretary of the Society, was made an honorary President of the St. Louis Medical Society.

Dr. Bradshaw stated that Dr. Hollingsworth, Secretary of the Henry County Medical Society for 41 years, will retire and he felt that a letter should be written to Dr. Hollingsworth expressing appreciation for his years of service.

Motion was made, seconded and adopted that a letter be sent to Dr. Hollingsworth expressing appreciation for his 41 years of service.

REPORT OF THE WOMAN'S AUXILIARY

Mrs. Lytton stated that she had attended the AMA Leadership Conference in Chicago and felt that it was excellent and educational.

The Woman's Auxiliary will have a Public Affairs Breakfast on Saturday, April 19 during the Annual Convention. The speaker at this breakfast will be Dr. Frank Jirka of Illinois.

Mrs. Lytton stated that the Auxiliary is still having some membership problems.

MSMA President-Elect Dr. Chandler asked that the Council members send in suggested names for Committee and Commission appointments for 1975-1976. These appointments will be made at the Annual Session in St. Louis. —Referred to Reference Committee on Reports of Officers.

LAY MEMBER ON BOARD OF HEALING ARTS

■ Mr. Cooper introduced Mr. Al Sikes, Director, Department of Consumer Affairs, Regulation and Licensing. Mr. Sikes indicated that he recommended a series of bills pending before the present Missouri Legislature, one of these recommendations being that a lay person be appointed to each of the 15 licensing boards and commissions. He pointed out that he felt that the essential purpose of the boards and commissions is to protect the consumer. He said that he felt the peer review process should certainly have principal control. In other words, doctors should have principal control over regulating doctors, etc. However, it is felt that there should be some consumer input on these Boards and Commissions. Mr. Sikes gave a few statistics on the number of complaints received from consumers. The states which have a consumer on their licensing boards generally report that it has been successful. Mr. Sikes indicated that at present the Board of Registration for the Healing Arts consists of five M.D.'s and two D.O.'s.

LEGISLATIVE REPORT

Dr. Matthews reported that of the 1,200 bills already introduced for consideration in the General Assembly, 110 have been tagged as bills which the MSMA will need to follow in varying degrees. Dr. Matthews briefed the Council on the following bills which are of special interest:

"*Senate Bill #1.* Introduced by Senator Cason. Would provide for the licensing of ambulatory care centers and provisions for payment to the centers by third parties. We had four witnesses to appear in support of this legislation. The MSMA House of Delegates in 1972 adopted a resolution establishing our position on ambulatory care centers. The only opposition to the bill during the Senate Public Health Committee meeting was voiced by the "Blues." This bill was reported out of Committee *Do Pass* and is the first bill on the Senate Calendar for Perfection. If we feel we have the necessary votes, it will be perfected next week. We urge you to contact your Senators and urge their support of this bill.

"*Senate Bills #59 & #60* were introduced by Senator Bradshaw to again provide for a medical examiner system for the state of Missouri. As you know, our Association has sponsored legislation of this type since 1955. The bill was passed during the last session of the General Assembly. The system provided for a medical examiner for Greene and Clay Counties. Cole, Boone, Callaway and Buchanan Counties have adopted this system by a vote of the people. Sections of the law passed were challenged by the coroner of the City of St. Louis and have been held unconstitutional by a lower court. The case has been heard by the Supreme Court and they are expected to deliver their decision by March 1. Because of the possibility that the lower court decision will be upheld, it was felt necessary to re-introduce this legislation because if the Supreme Court rules unfavorably, any county operating under this law would be left without the services provided. If a favorable Court decision is obtained, the bills will be struck by the sponsor. During the hearing held this week, an attempt was made to include chiropractors as medical examiners. The Committee rejected the amendments offered and the bill was reported out *Do Pass.*

"Other Senate bills that we will be supporting in the near future include *Senate Bill #73* introduced by Senator Spradling. It will provide for fluoridation of water except in cities and villages of the Fourth Class.

"*Senate Bill #165.* Sponsored by Senator Schneider. Will provide for insurance contract benefits for mental and nervous conditions.

"Other bills of interest in the Senate include the revision of the nurses practice act which we will follow closely and numerous bills relating to ambulance personnel and ambulance districts. We will oppose *Senate Bill #18* introduced by Senator Jack Gant. It would provide for the licensing of professional cardiology technologists."

The motion was made, seconded and carried to adopt this portion of the Legislative Report.

"There is much more activity on the House side. We appeared in favor of *House Bill #107* introduced by Dr. Roderick that would provide for the Uniform Anatomical Gift Act form to be printed on the reverse side of all motor vehicle operators and chauffeurs licenses. This bill has been reported out of Committee *Do Pass* and is on the perfection calendar. We have also given our support to *House Bill #166* introduced by Representative Schlef that would provide for a program for the prevention and control of alcoholism. No action has been taken by the Committee on this bill. A bill providing for the licensure of acupuncturists was re-introduced this year as *House Bill #318* by Representative Rothman, the majority floor leader of the House. The bill as introduced does not conform to our policy statements on the practice of acupuncture and we testified in opposition to the bill and offered the Committee a simple substitute. The original bill is approximately 15 pages. Our substitute bill is two sentences to the effect that acupuncture is the practice of medicine and that the State Board of Registration for the Healing Arts shall adopt rules and regulations regarding the practice of acupuncture. The acupuncture bill as introduced will probably create more problems for us this session than any other piece of legislation. We would appreciate the assistance of all of you and the physicians in your area in contacting representatives and requesting their opposition to the bill as introduced. No action has been taken by the Committee as of this morning on this legislation.

"*House Bill #342* introduced by Representative Scott would permit chiropractors to utilize physical therapy in their practice. The straight chiropractors, the Missouri Physical Therapy Association and the Medical Association appeared in opposition to this bill. No action has been taken to date.

"Other House bills that have been heard include *House Bill #305* that provides for the licensing of psychologists. As you know, we have had problems with this legislation because they refused to accept the umbrella concept of licensing of allied health personnel by the State Board of Registration for the Healing Arts and psychotherapy as defined by them constituted the practice of medicine. Their present bill provides for the umbrella concept of licensure and does not define psychotherapy. We will follow the bill closely.

"*House Bill #483* would eliminate coordination of benefits provisions in health and accident policies. You will recall that the Association is on record as opposing this concept.

"*House Bill #626* provides for the coverage of alcoholism in health and accident policies. We support this concept. We have appeared in support of *House Bill #216* which would provide implied consent for the test of blood alcohol. The bill has evidently been drafted incorrectly. The Highway Patrol and the sponsor of the bill are attempting to resolve the defects.

"We have listened to the testimony of the chiropractors on *House Bill #272* with great interest. This bill is a copy of crippling amendments that we used in the past in preventing the passage of chiropractic legislation. It is interesting that they are now sponsoring legislation of this type. It provides that a student applying for admission to a chiropractice college must have 60 hours of accredited college

Members of the Woman's Auxiliary to the MSMA elected and installed new officers for 1975-1976 during the Annual Convention in St. Louis. They are *(seated, left to right),* Mrs. W. Jack Stelmach, second vice-president; Mrs. George P. Wilson, president-elect; Mrs. William R. McPhee, president; Mrs. Sam Gaston, first vice-president; Mrs. Raymond Hartwig, fourth vice-president. *(Standing, left to right)* Mrs. Charles Workman, corresponding secretary; Mrs. E. E. King III, auditor; Mrs. J. Otto Lottes, third district director; Mrs. Harold Kanagawa, fifth district director; Mrs. Harry Raybuck, recording secretary; Mrs. James Nakada, fourth district director; Mrs. Donald Fakhoury, third vice-president; and Mrs. John Dernoncourt, first district director. New officers not pictured are Mrs. F. T. H'Doubler, treasurer; Mrs. William Hickerson, parliamentarian; and Mrs. Robert Buben, second district director.

The Auxiliary honored special guests at the luncheons on Friday and Saturday. *(Left to right)* MSMA President James C. Cope and Mrs. Cope; Mrs. Norman Gardner, First Vice-President of the Auxiliary to the AMA with Mrs. George J. Lytton, retiring president of the MSMA Auxiliary; newly-elected Auxiliary president Mrs. William R. McPhee with Mrs. James Manning, president of the Auxiliary to the Southern Medical Association; and Mrs. McPhee with Dr. R. Allen Chandler, who was elected President of the MSMA for 1975-1976.

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Mrs. Clarence Stratman *(left)*, president of Clay County Medical Auxiliary, accepts the Missouri State Medical Foundation Award from Mrs. Kenneth Siu, who represented Mrs. James Gordon, Auxiliary Chairman for the MSMF.

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Mrs. James A. Reid *(left)*, Public Affairs and MMPAC Chairman, and Mrs. Gerald L. Miller, Legislative Chairman, were on hand to urge all Auxiliary members to join MMPAC.

hours leading towards a baccalaureate degree as a condition for admission."

The motion was made, seconded and carried to adopt this portion of the report.

"Four Good Samaritan bills have been introduced in the House. The first of these will be heard next week and we will appear in support.

"Two bills have been introduced that would provide for some financing or scholarship payments to be made to certain medical students.

"Another bill that is introduced annually that we will appear in opposition to is *House Bill #450* introduced by Representatives Stone and O'Toole (55th). This is the bill that would change the Statute of Limitations for filing of malpractice suits whereby they must be filed within two years from the date of the act of neglect complained about is discovered. As you know, we have one of the most favorable Statute of Limitations of any of the states. Our present law requires the filing of suits within two years from the date of the act of neglect. We urge you to contact your representatives and senators now and express your opposition to this bill.

"Other bills of interest that we are following include *House Bill #237*. It would provide for a system of mobile radiologic vans to provide free examinations for the detection of breast cancer. This would provide for a van in each Congressional District. The fiscal note is over $2 million and would require $500,000 a year operating expense. The sponsors of the bill justified it by saying that it could save as many as 40 lives a day. Many highway safety bills have been introduced that we will study carefully and follow in the future. As in the Senate, there are several bills concerning ambulance attendants and ambulance districts. There also are bills introduced concerning birth certificates and burial permits."

The motion was made, seconded and carried to adopt this portion of the report.

"Another bill of interest that was heard by a committee this week is *House Bill #335*. It was introduced to protect the confidentiality of medical records. We have asked Dr. Domke and Dr. Robb for their advice on this bill.

"Of great interest to staff are the ten bills that have been introduced to regulate the activities of lobbyists.

"Another bill that we support is *House Bill #761* which was introduced by Representative Brockfeld and Dr. Roderick. This is an adaptation of the Florida bill and would provide for certification of physician assistants and the regulation of the supervising physicians of these assistants. This legislation conforms to the Council policy adopted at the September meeting.

"Next week, the House Public Health Committee will hear *House Bill #274*. This bill would permit only physicians, dentists, podiatrists and CRNAs to administer anesthesia. Some of our members who are practicing anesthesiologists are quite interested in this bill and will attend and listen to the testimony presented.

"Mr. Sikes, Director of the Department of Consumer Affairs, Regulation and Licensing, has discussed with you a bill proposed by the administration that will provide for a lay member on all the licensing boards. You will determine our position on this legislation today.

"I believe that I have included in this report most of the bills that are of interest to us. I do urge you to contact your representatives and senators and voice your opposition or support as I have discussed with you."

The motion was made, seconded and carried to adopt this portion of the report.

On motion, duly seconded, the report of the Legislative Committee was adopted as a whole.

After brief discussion, on motion of Dr. Bradshaw, duly seconded, it was agreed that the Council endorse the principle of allowing a lay member to be appointed to the State Board of Registration for the Healing Arts.—**Referred to Reference Committee on Miscellaneous Affairs.**

REPORTS OF THE DEANS

■ Dr. George Thoma, St. Louis University, discussed the bill passed last year by the General Assembly regarding informed consent for patients in human experimentation. This particular bill was vetoed by the Governor. We supported the veto due to some objectionable features in the bill regarding confidentiality, etc. Dr. Thoma indicated that Senator Payne has reintroduced that bill with the objectionable features removed. It is S.B. 404.

Dr. Noback indicated that the year-one students have completed the first semester of undergraduate work with a 3.5 average. Have lost only two students out of 72.

He stated that Dr. Malcolm Todd, President of the AMA, visited the school and was informed about it. Dr. Todd asked many good questions about the philosophy and the developments of the school.

Dr. Noback called the Council's attention to the Medline Program and indicated that this represents the most sophisticated program in the world on obtaining information on articles in the medical field. This program is carried out by the National Library of Medicine.

Dr. Noback stated that there may be a problem with a U. S. Senate bill recently introduced regarding photocopying of various articles. This process is widely used and has been a national issue for several years.

Dr. William C. Allen, University of Missouri-Columbia, reported that in all of the state schools, the applications to medical school were down and applicants increased considerably in private schools. In August, they will admit 110 new students, all of whom are residents of Missouri. Dr. Allen indicated that the highest correlation regarding where a physician goes to practice is where he takes his residency and then where he came from. About 50% of the MU-Columbia graduates have stayed in Missouri to practice and about one half of them practice in communities of less than 50,000.—**Referred to Reference Committee on Reports of Officers.**

REPORT OF THE DIRECTOR, MISSOURI DIVISION OF HEALTH

■ Dr. Domke again expressed his great concern regarding the incidence of venereal disease in the state and the apparent lack of reporting. He stated that this is a very critical problem and thanked Dr. Cope for his article regarding this problem which appeared in Missouri Medicine.

Dr. Domke stated that there is concern regarding the form that is to be filled out on abortions performed in Missouri. It was felt by many physicians that with the information requested on the patient, the patient could be identified. Dr. Domke indicated that this form was drafted with the aid and approval of the Attorney General's Office.

Following brief discussion, on motion of Dr. Hetlage, duly seconded, it was agreed that the MSMA Council go on record as looking upon the present form for abortion reporting which covers patient identification as a breech of confidentiality.

Dr. Domke said that the Governor had received a letter early last week setting out his responsibilities regarding the National Health Planning Act. Mr. Lawrence Graham, Director of the Department of Social Services, has been designated as the liaison person to work with the Regional Office of HEW. A task force has been set up to conduct the review and recommend the Health Service Areas in Missouri to the Governor. Dr. Domke stated that he understood that

Mr. William Mitchell, Director of CHP, has been designated as Chairman of this task force. It was felt that the MSMA would be invited to appear before this task force, but would not necessarily have a representative on the committee that would be submitting a report to the Governor.

On motion of Dr. Bregant, duly seconded, it was agreed that MSMA designate Dr. Clem Grebel to be appointed on this task force if possible to recommend the Health Service Areas in Missouri to the Governor.

Dr. Domke stated that the Hospital Discharge Program is on a voluntary basis and roughly three fourths of the Missouri hospitals are participating voluntarily and this is a few more than were previously involved. There will be an analysis of the cost of the program. Dr. Domke recommended that the MSMA might determine how best, in its judgment, various kinds of patient or hospital data can be collected. Dr. Domke stated that obviously PSROs are going to be interested in this.

Dr. Domke reported that there is a cancer program proposal to attempt to establish in Missouri a multi-state regional program. The Governor, Mr. Ratchford of the University of Missouri-Columbia and the Cancer Research Center have agreed to the filing of incorporation papers for an agency to make application for such a multi-state program. Dr. McCanse indicated that four regional cancer centers will be included and one will cover all or parts of Missouri.

FAMILY PHYSICIANS FOR RURAL MISSOURI

Dr. William Bradshaw gave a report on the State Board of Health Ad Hoc Committee on Family Physicians for Rural Missouri and outlined the issues to be addressed by this Committee as follows:

I. Educational factors affecting likelihood of entering rural practice.
  A. *Postgraduate education.*
  Increasing the number of family medicine residency opportunities within the state.
  B. *Undergraduate education.*
  Improving selection procedures for admission to M.D./D.O. degree programs.
  C. *Continuing education.*
  Increasing the availability of continuing education programs throughout the state.

II. Local factors affecting selection of practice location.
  A. *Community factors.*
  These include such factors as community size and location, economic opportunities, community interest, quality of schools, cultural opportunities, etc.
  B. *Professional factors.*
  These include accessibility to facilities such as hospitals, relationships with other professionals in the area (which may be formal or informal), opportunities for consultation, etc.
  C. *Other factors.*
  These are not presently well-defined, but include such factors as the potential impact of the National Health Service Corps, Comprehensive Health Planning, Professional Standard Review Organizations and National Health Insurance.

Dr. Bradshaw stated that in this first report, the committee has addressed itself to the postgraduate education aspects and indicated that they had many supporting documents and would like to make the following recommendations regarding the postgraduate education aspects:

1. The state of Missouri should implement legislation to support graduate training of physicians in Family Medicine.
2. Over a three-year period, support should be incremented to provide a total of 50 resident positions at each of the three year levels.
3. Support should be provided on a capitation per resident basis and should reflect approximately half the operational cost of the program. A logical support figure initially would be $17,125 per resident.
4. Funds should be allocated by the Board of Health to programs which have been accredited and are affiliated with a school of medicine or osteopathy.
5. Relative preference in allocation of funds should be given to those programs which seem most likely to educate physicians for rural practice.
6. Capital support must be provided to make possible construction or renovation of structures to become model offices for Family Medicine residencies.

The Committee feels that implementation of the above recommendations will markedly increase the number of physicians interested in rural practice. The achievement of the goal of increasing physicians in rural Missouri, however, will require not only the education of physicians with an interest in rural practice but, also, enhancement of local communities as a site for practice. The next report of the Committee will direct itself to means whereby specific rural communities can be made more attractive as a place for practice.

Dr. Bradshaw requested that the staff send copies of the Committee's report to the Council.—**Referred to Reference Committee on Medical Education and Public Welfare.**

117TH ANNUAL SESSION MATERIAL

■ Mr. Swarens reported that as of this date, we have received only one resolution to be included in the Delegates' Handbook. He reminded the Council to reiterate to their county medical societies that March 1 is the deadline for inclusion of resolutions in the Handbook. The preliminary program will be sent out in the latter part of February. Exhibits seem to be picking up this year.

NEXT COUNCIL MEETING

The next meeting of the Council will be held at 3 PM on Wednesday, April 16, in the Tiara Lounge South on the 26th Floor of the Chase-Park Plaza Hotel in St. Louis prior to the opening of the MSMA 117th Annual Session.

The Council adjourned at 4 PM and then held a short Executive Session.—**Referred to Reference Committee on Reports of Officers.**

Supplementary Council Report

Dr. Franklin then presented a supplementary report on the Council Meeting held on Wednesday, April 16, 1975 in the Chase Park Plaza Hotel in St. Louis. He reported as follows:

"The Council of the Missouri State Medical Association met in regular session on Wednesday, April 16, 1975, in the Chase-Park Plaza Hotel with a quorum present.

"The motion was made and seconded to approve the February 8, Council Minutes. Dr. McAlhany indicated that there have been unfavorable comments regarding the action taken by the Council at the February meeting as follows:

'After brief discussion, on motion of Dr. Bradshaw, duly seconded, it was agreed that the Council endorse the principle of allowing a lay member to be appointed to the State Board of Registration for the Healing Arts.'

"He stated that he felt this was a precipitous action of the Council and moved that the Council rescind this action and accept the report of Mr. Al Sikes at the February meeting for information only. This motion was seconded and carried. The remainder of the Council Minutes were approved.

(The Speaker **referred this portion of the report to the Reference Committee on Miscellaneous Affairs.**)

"Mr. Jim Hamilton, Vice-President of Rollins Burdick

Hunter Co. distributed samples of the brochures that will be sent to MSMA members regarding the professional liability insurance program and indicated that representatives of his firm will be available throughout the meeting to provide information on this program.

"Dr. McAlhany reported that on March 24 in Springfield, Missouri, the MSMI, Inc. was officially incorporated. MSMI, Inc. is a for-profit corporation owned solely by MSMA and will soon be licensed as an insurance agency.

"Dr. McAlhany reported that MSMI (Missouri State Medical Insurance, Inc.) had designated Shand, Morahan and Company, Inc. as the official underwriters for the professional liability program and asked for Council approval for the following two motions:

"1. That the Council give the three MSMA directors on the MSMI Board—Drs. McAlhany, Clark and Mr. Royal O. Cooper—the authority to vote MSMA shares at any properly called meeting. The motion was seconded and carried.

"2. That the Council authorize the purchase of 200 shares of MSMI stock at $10 per share. The motion was seconded and carried.

(The Speaker referred this portion of the report to the Reference Committee on Constitution and Bylaws.)

"Mr. McIntyre reported that it is again time to appoint the Editor for Missouri Medicine. On motion, duly seconded, it was unanimously agreed that Dr. Joseph V. Finnegan of St. Louis be reappointed Editor of Missouri Medicine.

"Mr. Royal O. Cooper asked for Council approval for sponsorship of a trip to the South Pacific in January or February, 1976. On motion, duly seconded, it was agreed that MSMA will sponsor such a tour.

"Dr. Cope indicated that the 'Friends of Arrow Rock' are establishing a medical museum and are seeking MSMA-sponsorship in this endeavor. A motion was made, seconded and carried that MSMA extend such sponsorship and recognize this as a worthy endeavor.

(The Speaker referred this portion of the report to the Reference Committee on the Reports of Officers.)

"Dr. Cope said that the State Board of Health has asked that MSMA appoint two members to meet with them regarding regulations concerning smoking in hospitals. Dr. Cope suggested Dr. Leroy Miller of Columbia as one of these members and indicated he would appoint a second member.

"Dr. Cope stated that a question had arisen regarding the award given to the top senior medical student of each of the four medical schools in Missouri as to whether or not MSMA wished to increase this amount. The motion was made, seconded and carried that the present award of $100 to be continued.

"Dr. Cope received a letter from the President of the Missouri Dental Association requesting MSMA approval of their beginning project regarding hypertension detection. If the dentist detects an elevated blood pressure, he will advise his patient to see his own physician. It was moved, seconded and carried that MSMA commend the Dental Association for their efforts and wish them luck with their project.

(The Speaker referred this portion of the report to the Reference Committee on Medical Education and Public Welfare.)

"Dr. John Martin, a member of the Board of Healing Arts, reported on some recent administrative problems concerning the Board. After brief discussion of this matter, Dr. Hetlage presented the following resolution:

Whereas, Recent actions of the Department of Consumer Affairs, Regulation and Licensing which, under the recent reorganization bill, has gained administrative control over the Board of Healing Arts, have had the following effect:

1. To require the replacement of the present Executive Secretary against the wishes of the Board of Healing Arts.

2. To indicate to the Board of Healing Arts that the prerogative of the Board to appoint its own Executive Secretary, will be withdrawn.

3. To indicate that this appointment will be made as a political one without approval of the Board of Healing Arts despite the opinion of the Governor that the Director and the Board, 'act in concert to employ a replacement.'

4. To assume the previously held investigative power of the Board of Healing Arts to conduct such investigations outside of Board knowledge and approval and

Whereas, The Board of Healing Arts has functioned in the past in an efficient and professional manner, well representative of the ethics and standards of the medical profession without administrative interference, therefore be it

Resolved, That the Council of MSMA goes firmly on record as strongly opposing administrative interference with the operation of the Board of Healing Arts and further be it

Resolved, That the attitude of MSMA on this matter be conveyed to the legislators of the State of Missouri and to the Governor for their information and action.

"The resolution was approved.

(The Speaker referred this portion of the report to the Reference Committee on Miscellaneous Affairs.)

"Mrs. Lytton reported that the MSMA Woman's Auxiliary has had a good year and now has 1,760 members, which represents an increase of approximately 10%. She reported that at this meeting, an important item on the agenda is the ratification of an amendment to the Auxiliary's Articles of Incorporation. There also will be a discussion regarding an increase in national Auxiliary dues.

"She thanked the Council for the privilege of attending its meetings during the past year and invited the Councilors to attend the reception for Mrs. William R. McPhee, President-Elect, on Friday evening.

(The Speaker referred this portion of the report to the Reference Committee on Reports of Officers.)

"Dr. McAlhany reported on the Medical-Legal Pre-Trial Screening Panel Plan recently adopted by the Jackson County Medical, Bar and Osteopathic Associations. The MSMA Medical-Legal Commission recommended adoption of this plan. However, since the formation of the Missouri State Medical Insurance, Inc., it was felt that, perhaps, we should seek the comments and suggestions of our insurance underwriters prior to taking such action. Therefore, it was moved that this Council accept the report of the Medical-Legal Commission as information only and postpone action until the May meeting. The motion was seconded and adopted.

(The Speaker referred this portion of the report to the Committee on Constitution and Bylaws.)

"On recommendation of Dr. Finnegan, it was moved, seconded and carried that the present members of the Editorial Board and the Publications Committee be reappointed.

(The Speaker referred this portion of the report to the Reference Committee on Reports to Officers.)

"Dr. Paul R. Young reported that the AMA has approved MSMA's Continuing Medical Education proposal which lays all the elements in place for the implementation of our CME program. Dr. Young indicated that he would be leaving Missouri to join the Department of Family Practice at the University of Nebraska, but felt that Missouri has the leadership, expertise and zeal necessary to implement the CME program.

"On motion of Dr. Bradshaw, duly seconded, it was agreed to accept the report of Dr. Young. Dr. Bradshaw requested that the Council stand and give Dr. Young a round of applause for a job well done.

"Dr. Bradshaw moved that Dr. Paul Young be properly recognized by the House of Delegates for the outstanding services he has provided to the MSMA. Dr. Cope has already seen to that.

(The Speaker referred this portion of the report to the Reference Committee on Medical Education and Public Welfare.)

"Mr. Cooper presented a current legislative report concerning the many medical and health-related bills presently being considered by the Missouri General Assembly. Among these the following were discussed:

"The Chiropractors have succeeded in gaining house passage of House Bill #342, which would expand their practice in treating patients to include the use of heat, cold, water, sound and electricity. This constitutes the practice of physical therapy which, under current state law, is considered to be authorized only under the supervision of a physician. All physicians should contact their state senators expressing opposition to this bill.

"The Acupuncture Bill, House Bill #318, will be up for a vote on the floor of the House in the next two or three weeks. Our Association and the State Board of Healing Arts have taken the position that acupuncture is in the practice of medicine. Under this bill, untrained persons with only a few hours of training would be eligible for licensure to practice acupuncture in our state. It is imperative that physicians contact their representatives immediately and ask them to oppose House Bill #318.

"Senate Bill #1 provides for the licensing of ambulatory care centers. It has passed the Senate and was heard last night by a House Committee. Physicians should contact their representatives and ask for their support on passing this MSMA-approved legislation.

"Senate Bill #458 is enabling legislation that would allow associations to establish mutual professional liability insurance companies to provide malpractice insurance for their members. Our friends in the Senate sponsored this bill and it was passed yesterday by the Senate by a vote of 32 to 0. Physicians should urge their representatives to support this bill in the House.

"House Bill #237 provides for mobile breast cancer detection units. The original bill asked for a mobile unit for each congressional district. The sponsor of the bill has agreed that a trial unit could be established. This unit would be under the supervision of the Missouri Division of Health and the Ellis Fischel State Cancer Hospital. The Council approved support of the proposed trial unit as an experimental modality. Hopefully, if this legislation is adopted, rules and regulations promulgated will provide for an examination by a physician.

"On motion, duly seconded, the Council accepted the report of the Legislative Committee.

(The Speaker referred this portion of the report to the Reference Committee on Miscellaneous Affairs.)

"Dr. Frank Jirka, a member of the AMA Board of Trustees, reported that Illinois is now working on malpractice legislation and also brought the Council up-to-date on the AMA suit against HEW.

"Dr. Bregant reported on his activities as a member of the Governor's Task Force to determine Health Service Areas under the National Health Planning and Resources Development Act of 1974. Six hearings were held throughout Missouri and the Task Force has completed its work and a report will be submitted to the Governor.

"Dr. McAlhany reported that several physicians in his district received subpoenas in regard to their activities on review panels of the Health Care Foundation. They gave depositions in regard to a suit brought by a physician against a hospital located in Rolla.

Dr. Hubert A. Ritter *(left)*, MSMA Delegate to the AMA, and MSMA President James C. Cope *(right)* welcome James W. Foristel, assistant director of the AMA Department of Congressional Relations, Washington, D. C.

(The Speaker referred this portion of the report to the Reference Committee on Resolutions.)

"Mr. Speaker, this concludes the supplementary report of the Council."

(The supplementary report of the Council was accepted.)

NOMINATING COMMITTEE

Dr. Cope named the following members to the Committee on Nominations: Drs. John R. Dixon, First District; Stanley G. Hall, Second District; Max S. Franklin, Third District; John M. Laird, Fourth District; William B. See, Fifth District; William D. Bradshaw, Sixth District; Warren F. Wilhelm, Seventh District; H. B. Ivy, Eighth District; Jack N. Wiles, Ninth District; and Harold B. Rapp, Chairman, Tenth District.

Unfinished Business

The Speaker invited consideration of unfinished business.

The Speaker then asked the Delegates to consider *Resolution #40—Unified Membership with the American Medical Association,* which had been held over from the 116th Annual Session of the MSMA in 1974 and reads as follows:

Resolution #40—Unified Membership with the American Medical Association (1974)

Whereas, The American Medical Association, a federation of state medical associations, is dedicated to acting in the best interests of all physicians; and

Whereas, The states of Arizona, California, Hawaii, Illinois, Oklahoma, New York and Wisconsin have voluntarily recognized that the strength of our federation is measured by our degree of unity by establishing constitutional policies for unified membership; and

Whereas, The AMA provides services to all state medical associations on an appeal basis without regard to the number of state members who support the AMA through membership; and

Whereas, The AMA House of Delegates at the Clinical Meeting in November, 1972 adopted the policy, "that all state medical associations should be considered having all members support all levels for our national federation by adopting, where possible, the unified concept"; therefore be it

Resolved, That changes in the Bylaws of the MSMA be considered to the effect that all members of the Association shall also be members of the AMA, and be it further

Resolved, That the Council of the MSMA be instructed to assure that full and ample discussion of this important issue occur in each of the Councilor Districts and each of the county societies to the end that this Resolution in a formal manner be brought before the House of Delegates at the first session of the 1975 Annual Meeting of this Association.

(The Speaker explained that this resolution was held over from the 116th Annual Session since it requires a

change in the MSMA Constitution and Bylaws. Adoption would require a two-thirds vote of the House.

After discussion by two delegates, the Speaker called for a standing vote on Resolution #40. The vote was 92 to 64. Since the required majority was 106 votes, the resolution failed.)

Introduction of New Business

The Speaker noted that since Resolutions #1 through #34 had been submitted in time for inclusion in the Delegates Handbook, their introduction from the floor is not required. These resolutions are as follows:

Resolution #1—Certificate of Birth

(Introduced by Butler-Wayne-Ripley-Carter County Medical Society)

Whereas, The Certificate of Birth records as required by the Division of Health of the state of Missouri inquire as to whether a newborn is "legitimate" or "illegitimate," and

Whereas, The denoting of a newborn as "illegitimate" places an unnecessary handicap on that child, be it therefore

Resolved, That the Division of Health be requested to delete the legitimacy item from the Certificates of Birth; and be it further

Resolved, That should the Division of Health fail to remove the above-mentioned item from the Certificates of Birth, that proper legislation be placed before the Missouri General Assembly to carry out the elimination of the item relating to legitimacy.

(Referred to Reference Committee on Medical Education and Public Welfare.)

Resolution #2—Invasion of Patient Privacy by Governmental Agencies

(Introduced by St. Louis County Medical Society)

Whereas, There have recently been attempts by various governmental agencies to require physicians, hospitals and other providers of health care to report information concerning diagnoses, procedures and other personal matters in a form which would make the individual patient easily identifiable; and

Whereas, We feel that collection of such data represents a clear invasion of the patient's privacy and of the confidentiality of the patient-physician relationship; and

Whereas, These efforts will undoubtedly increase if not challenge; now, therefore be it

Resolved, That the Missouri State Medical Association encourages its members to refuse to submit such material.

(Referred to Reference Committee on Resolutions.)

Resolution #3—Establishment of a Professional Liability Committee

(Introduced by St. Louis County Medical Society)

Whereas, The Missouri State Medical Association is actively engaged in creating a medical insurance liability program for its members; and

Whereas, The physicians of the state of Missouri are concerned about the availability of medical liability insurance coverage and legislation relative to malpractice; now, therefore be it

Resolved, That the House of Delegates of Missouri State Medical Association goes on record as recognizing the need for the establishment of a Professional Liability Committee, both on a state and local level, to screen malpractice claims. Such a Committee should work in conjunction with the insurance carriers and representatives of the legal profession, and to seek the establishment of remedies in the area of malpractice claims.

(Referred to Reference Committee on Constitution and Bylaws.)

Resolution #4—Meeting of Component Medical Societies

(Introduced by St. Louis County Medical Society)

Whereas, The component Medical Societies of the Missouri State Medical Association have at present no forum for exchange of ideas regarding local medical society policy and problems; and

Whereas, The need for medical unity and mutual cooperation and understanding is a basic prerequisite of the continuation of the private practice of medicine as we know it, especially on the grass roots level of organized medicine; and

Whereas, The component medical societies are best equipped to suggest and help each other with local matters through open exchange of ideas; and

Whereas, The Missouri State Medical Association as a body has the expertise for providing this exchange of ideas only by causing a meeting of the component medical societies; now, therefore be it

Resolved, That the House of Delegates of the Missouri State Medical Association directs the President to appoint an Ad Hoc Committee to organize a meeting of the representatives of the component medical societies.

(Referred to Reference Committee on Reports of Officers.)

Resolution #5—Intent of Public Law 92-603

(Introduced by Michael G. Murphy, M.D., St. Louis Medical Society)

Whereas, The original concept of Public Law 92-603, 92nd Congress, HR #1, was to provide for a "grass roots" quality control mechanism to be implemented by practicing physicians, and

Whereas, The contracting process to establish and regulate PSROs is not a public process in that it involves only the involved government and the private contractor, and

Whereas, The present law vests all ultimate PSRO authority in the Secretary of HEW, and

Whereas, The National Professional Standards Review Council has been charged with approving norms utilized by local PSROs that depart from regional norms, and

Whereas, These practices are depriving the PSRO of its "grass roots" character, now therefore be it

Resolved, That the Secretary of Health, Education and Welfare be advised of the original intent of Public Law 92-603 and advise the members of his bureaucracy of the intent of the law with regard to the local development of norms, criteria and standards, and be it further

Resolved, That the implementation of the PSRO law through unpublished edict cease and return to implementation of this process through public involvement in open rule making.

(Referred to Reference Committee on Resolutions.)

Resolution #6—Missouri Hospital Record Abstract Sheet

(Introduced by Charles S. Sherwin, M.D., St. Louis Medical Society)

Whereas, The Director of the Division of Health of the state of Missouri, under authority granted under the Missouri Hospital Licensing Law, which law requires the filing of "a monthly report" "providing information on patients discharged from the hospital in a manner and containing information prescribed by the Division of Health," had scheduled mandatory reporting of specific data regarding such discharged patients, beginning on January 1, 1975, and

Whereas, The requiring of such mandatory reporting was set aside, at least temporarily, after pressure placed upon the Division of Health by hospital administrators and other interested parties, and

Whereas, Such reporting would have been a mandatory extension of the similar system designated as the "Icepick Program," a small voluntary program in operation since 1963, and

Whereas, Certain items originally printed on the abstract of each individual patient would have permitted identification of such patient, and

Whereas, The cost of hospitalization, widely commented upon in the press and elsewhere, is largely a direct reflection of the cost of maintaining and staffing and operating each individual hospital, and

Whereas, A substantial and increasing portion of such cost may be attributed to the duties required in compiling and preparing reports of, and meeting other obligations to external agencies, including some third party payors, and governmental agencies, and

Whereas, The Missouri Record Abstract sheet, as originally scheduled prior to the program's cancellation in late 1974, purported to require much additional data beyond that required in most such reports, and in a code not previously employed by all hospitals in the State of Missouri, and in a form not required of hospitals in Missouri by any other such external agency, and thus promised to add an additional substantial load to such secretarial activities, therefore be it

Resolved, That the House of Delegates of the Missouri State Medical Association recommends that the date of commencement of the required reporting of information on the Missouri Hospital Discharge Data Set or any similar Data Set, be delayed indefinitely, and be it further

Resolved, That the House of Delegates of the Missouri State Medical Association recommends that the Division of Health of the State of Missouri request the cooperation of all interested parties in the establishment of a simplified and uniform discharge data form, such as the Health Insurance Council form established through cooperation of the AMA and the Health Insurance Council; and that the parties to be invited include all PSRO organizations throughout the state, including CEMPROC and its counterparts, the Health Care Foundation of Missouri, Medicare, Medicaid, Health Delivery System and other federally funded demonstrations, comprehensive health planning agencies such as Arch in St. Louis, the respective Medical Societies, interested hospital organizations and representative patients, and be it further

Resolved, That the House of Delegates of the Missouri State Medical Association further recommends that in any such uniform reporting form, precautions be incorporated to withhold any and all identifying information from such central information banks as were contemplated by the Missouri Division of Health, and be it further

Resolved, That a copy of this resolution be forwarded to the Director of the Division of Health of the State of Missouri, to Lieutenant Governor William Phelps, and to the Delegates from the Mis-ouri State Medical Association to the American Medical Associaion.

Note: A Health Services Data System Medical Record Abstract orm accompanied Resolution #6 as an addendum. Copies may be btained by writing to the MSMA, 113 Madison, Jefferson City 65101.)

(Referred to the Reference Committee on Medical Eduation and Public Welfare.)

Courtesy Resolution #7—Gov. Christopher S. Bond

(Introduced by MSMA Ad Hoc Committee on
Emergency Medical Services Commission on
Public Affairs.)

Whereas, Governor Christopher Bond has demonstrated his acive interest in Emergency Medical Care for the citizens of this tate, and

Whereas, Under the administration of Governor Bond significant dvances have occurred, and

Whereas, The physicians of the state are concerned about the vailability of Emergency Medical Services in this state, now, thereore, be it

Resolved, That the House of Delegates of MSMA goes on record s recognizing the dedication of Governor Bond in this cause and xpress their appreciation for his many efforts.

(Referred to Reference Committee on Miscellaneous Afairs.)

Courtesy Resolution #8—Herbert R. Domke, M.D., Director, Missouri Division of Health

(Introduced by MSMA Ad Hoc Committee on Emergency
Medical Services Commission on Public Affairs)

Whereas, Herbert R. Domke, M.D., has demonstrated his interst in improving the availability of Emergency Medical Services for he citizens of this state through the services of the Division of Health and,

Whereas, Herbert R. Domke, M.D., has provided funds to imlement the licensing of ambulances of this state and,

Whereas, The members of MSMA appreciate the need to imrove Emergency Medical Services in this state, now therefore, be t

Resolved, That the House of Delegates of MSMA goes on record s recognizing the efforts of Herbert Domke in this cause and exress their appreciation for his efforts.

(Referred to the Reference Committee on Miscellaneous ffairs.)

Resolution #9—Professional Liability Legislation

(Introduced by Jackson County Medical Society)

Whereas, The cost of professional liability insurance for physiians in the state of Missouri has increased dramatically during the ast two years, thus increasing the cost of medical care; and

Whereas, Some insurance carriers are no longer writing profesional liability policies, thereby making "coverage" difficult to obain in certain instances; and

Whereas, The only effective remedy for this growing problem is n changing existing laws and judicial procedures to make them more esponsive to the changing needs of society; therefore, be it

Resolved, That the Missouri State Medical Association calls on he Missouri General Assembly to take remedial action to assure the vailability of quality medical care at a reasonable cost by changing he State laws pertaining to professional liability by:

1. Altering the contingency fee system for attorneys and establishing a sliding fee scale or a straight fee-for-service rendered system;
2. Applying the Workmen's Compensation principle of established ranges of compensation for specific degrees of injury;
3. Requiring mandatory arbitration of claims by a qualified impartial panel;
4. Prohibiting fee splitting among attorneys in the referral of possible malpractice cases; and be it further

Resolved, That the Missouri State Medical Association commends the Senate of the Missouri General Assembly for considering the establishment of a special committee to study the problems of professional liability with the intent to develop remedial legislation; and be it finally

Resolved, That copies of this resolution be distributed to the Governor of the state of Missouri and all members of the Missouri General Assembly for their respective information and possible assistance.

(Referred to Reference Committee on Constitution and Bylaws.)

Resolution #10—Providing Up-To-Date Procedures for Checking on Patients' SSA Eligibility Status

(Introduced by Richard V. Bradley, M.D.,
St. Louis Medical Society)

Whereas, The recipients of many services under Social Security are restricted in the extent of those services by an eligibility system; and

Whereas, Instances have arisen and may continue to arise where those eligibility limits may have been wholly or partly exhausted at the time of patient application for further services under SSA; and

Whereas, The hospitals and attending physicians might unknowingly place the patient in a difficult position by permitting services to over-extend their eligibility under the SSA program; and

Whereas, The long delays in reporting are causing undue financial burden to patients and hospitals alike; and

Whereas, Relatively simple mechanisms are presently in existence which would permit checks on a patient's eligibility status in a matter of minutes by telephone by stating the patient's card number; and

Whereas, April 1, 1975 has been set for the current utilization regulations to become effective, therefore be it

Resolved, That the Missouri State Medical Association petitions the state agencies who pay for SSA recipients to effect a change in procedure, and be it further

Resolved, That the AMA petitions the Department of SSA to provide eligibility data on all recipients by numbered phone or letter upon request whenever an eligible recipient applies for service, and be it further

Resolved, That copies of this resolution be forwarded to: The Governor and Legislature of Missouri, Senators and Representatives from Missouri, The Officers and trustees of the American Medical Association, American Hospital Association, American Association of Physicians and Surgeons, American Academy of Family Physicians, American College of Surgeons, American College of Physicians, Department of Health, Education and Welfare, Department of Social Security Administration, and be it further

Resolved, That this resolution be presented by Missouri delegates to the next AMA session House of Delegates for action at the national level.

(Referred to Reference Committee on Resolutions.)

Resolution #11—Politics in VA Hospitals

(Introduced by Richard V. Bradley, M.D.,
St. Louis Medical Society)

Whereas, The Senate of the United States passed Public Law 92-603; and

Whereas, The House of Representatives of the United States passed Public Law 92-603; and

Whereas, Section 249F of Public Law 92-603 relieves the legislative branch of the government from any utilization review in public and private hospitals by placing said responsibility with the department of HEW; and

Whereas, The Senate and House of Representatives have long been encumbered with frequent patient and Veterans representative requests to intercede in matters pertaining to medical care in Veterans Hospitals; therefore be it

Resolved, That all requests by patients and Veterans' representatives rendered to Senators, or Representatives, or their staff, personnel, be sent direct to the department of HEW without benefit of a personal form letter answer from the legislator to the patient or his Veterans' representative, and be it further

Resolved, That the House of Delegates of MSMA directs the Missouri delegates to the AMA to place this resolution before the next session of the AMA House of Delegates for action at a national level and, be it further

Resolved, That the Speaker of the House of Delegates directs the MSMA staff to send copies of this resolution without delay to: The Governor and the Legislature of Missouri, Senators and Representatives from Missouri in the Congress of the United States, Officers and trustees of the American Medical Association, American Hospital Association, American College of Physicians, American College of Surgeons, American Association of Physicians and Surgeons, American Academy of Family Physicians.

(Referred to Reference Committee on Resolutions.)

Resolution #12—Apply PL 92-603 (Section 249F) to Government Hospitals in Missouri

(Introduced by Richard V. Bradley, M.D.,
St. Louis Medical Society)

Whereas, Section 249F, PL 92-603 was approved by the Senate, House of Representatives and signed into law September 30, 1972 as a cost containment measure for medical services rendered to persons under Social Security, and

Whereas, Section 249F, PL 92-603 contains the implication that unnecessary medical services may be provided to persons under Social Security, and

Whereas, Section 249F, PL 92-603 ascribes to the Secretary of Health, Education and Welfare, unilateral authority to the survey of privileged communication between patients and their physician if the patient comes under Social Security, and

Whereas, Section 249F, PL 92-603 contains no contract responsibility on the part of the patient in contrast to minutely detailed contract responsibility for health care providers, and

Whereas, Conduct of Affairs stated in Section 249F, PL 92-603 would compromise the quality of medical care in favor of reducing the cost of medical care, and

Whereas, Application of the intent of Section 249F, PL 92-603 would cause physicians, hospitals and supporting specialities of the Private Sector to work out the errors and trials of this program, and

Whereas, The time required to experiment with the implementation of Section 249F, PL 92-603 would need to be subtracted from time spent in actual patient care, and

Whereas, The Department of Health, Education and Welfare lacks sufficient funds to implement the PSRO Program in those geographical areas selected by the Secretary, therefore be it

Resolved, That the House of Delegates of the Missouri State Medical Association, acting for the patients, physicians, hospitals, extended care facilities and supporting specialities who deliver or receive medical care under the auspices of Social Security or HEW, in Missouri

1. Requests of the Social Security Administration and the Department of HEW, that Section 249F, PL 92-603 be applied in Government owned and controlled hospitals and extended care facilities now in operation in the State of Missouri for a period of two years.
2. Requests of the Social Security Administration and Department of HEW, a report on this experiment publicly to the citizens of Missouri at the end of two years as to benefits derived and problems encountered.
3. Requests that any implementations of Section 249F, PL 92-603 be deferred in non-governmental Missouri institutions pending above report.
4. Directs the Missouri delegates to the AMA to place this resolution before the next session of the AMA House of Delegates for action at a National level.
5. That copies of this petition be sent without delay to: The Governor of Missouri and the Legislature of Missouri, Senators and Representatives from Missouri in the Congress of the United States, Officers and trustees of the American Medical Association, American Hospital Association, American College of Physicians, American College of Surgeons, American Academy of Family Physicians, American Association of Physicians and Surgeons.

(Referred to Reference Committee on Resolutions.)

Resolution #13—Action on Professional Liability

(Introduced by Paul F. Max, M.D.,
Delegate, St. Louis)

Whereas, Medical malpractice insurance has become exorbitantly expensive and often even unobtainable, and

Whereas, "Claims made" policies proposed are in reality no durable policies and as expensive or often more so, and

Whereas, Many physicians are forced to early retirement or cessation of practice because of these facts and in the face of a shortage of physicians, and

Whereas, The high cost of medical care is increasing at a rapid rate and will even be accelerated by these facts and should be of grave concern to everyone, now therefore be it

Resolved, That the Missouri State Medical Association makes every effort to urge the Missouri State Legislature to pass regulations similar to the Workmen's Compensation Law, and be it further

Resolved, That the AMA be notified of our action in this matter, be requested for aid and be assured of our willingness to cooperate with any actions they contemplated.

(Referred to Reference Committee on Constitution and Bylaws.)

Resolution #14—Contingent Fee System

(Introduced by St. Louis County Medical Society)

Whereas, The frequency of medical malpractice litigation has greatly increased in recent months; and

Whereas, The contingent legal fee system contributes to both the frequency and excessiveness of litigant demands; and

Whereas, The eventual burden of this litigation must be borne by the physician and ultimately by our patients; now, therefore, be it

Resolved, That the Missouri State Medical Association favors initiation of legislative efforts to limit or regulate the contingent fee system.

(Referred to Reference Committee on Constitution and Bylaws.)

Resolution #15—Development of Individual Practice Associations

(Introduced by St. Louis County Medical Society)

Whereas, There are increased pressures for the formation of alternative health care delivery systems such as HMOs; and

Whereas, Their status in relationship to other types of group practice is not well defined; and

Whereas, It is our understanding that in the recently passed HMO legislation, individual practice associations may be offered as an alternative to an HMO; now, therefore, be it

Resolved, That the Missouri State Medical Association looks into the development of individual practice association as to provide this alternative in the State of Missouri.

(Referred to Reference Committee on Resolutions.)

Resolution #16—Student Participation

(Introduced by Boone County Medical Society)

Whereas, It has become apparent to physicians in recent years that it is to our advantage to get medical students interested in organized medicine early, and

Whereas, The Missouri State Medical Association has recently admitted two medical students from each medical school to the House of Delegates of the MSMA, and

Whereas, This does not really give a broad number of medical students exposure to organized medicine in our state, and

Whereas, The Missouri Academy of Family Physicians has for the past several years invited medical students to its annual meeting at the Lake of the Ozarks and, in 1974 invited any medical student who wished to attend the scientific session of this meeting, and

Whereas, The expenses of the medical students were paid for by voluntary contributions from members of the Academy, therefore, be it

Resolved, That the Missouri State Medical Association will invite any and all medical students from the state of Missouri to attend its annual session and will ask for voluntary contributions from the members to defray their expenses.

(Referred to Reference Committee on Medical Education and Public Welfare.)

Resolution #17—PSRO

(Introduced by Leonard L. Davis, Jr., M.D.,
Audrain County Medical Society)

Whereas, The Congress of the United States has passed a law encompassing professional standards review commonly known as PSRO, and

Whereas, The physicians of Missouri strongly disapprove of the involvement of the federal bureaucracy in the delivery and/or surveillance of the delivery of medical care, and

Whereas, The physicians of Missouri believe the implementation of the PSRO law will reduce rather than enhance the overall quality of medical care, therefore be it

Resolved, That this House of Delegates of the Missouri State Medical Association calls upon the Senate and House of Representatives of the United States to repeal the PSRO legislation, and be it further

Resolved, That copies of this resolution be sent to President Ford, Senators and members of Congress from Missouri, the American Medical Association and the Missouri delegates to the AMA.

(Referred to Reference Committee on Resolutions.)

Resolution #18—Malpractice Crisis—No Fault Insurance

(Introduced by Ray Wilbers, M.D.,
Audrain County Medical Society)

Whereas, Claims of malpractice and associated legal actions are rapidly increasing in number, and

Whereas, Jury awards in successful malpractice actions are rapidly escalating, and

Whereas, Premiums for malpractice insurance are rampantly increasing, and

Whereas, Several insurors are declining to renew malpractice insurance policies held by Missouri physicians, therefore, be it

Resolved, That this House of Delegates of the Missouri State Medical Association calls upon the legislature to pass all necessary legislation to establish a system of no fault malpractice insurance, such legislation to include the outlawing of the contingent fee for malpractice lawyers, and be it further

Resolved, That copies of this resolution be sent to Governor Bond and to each of the state legislators.

(Referred to Reference Committee on Constitution and Bylaws.)

Resolution #19—Tract V Program of AMA

(Introduced by William Jolly, M.D.,
Audrain County Medical Society)

Whereas, Residents of Missouri currently are, and will be in the future, enrolled in foreign medical schools, and

Whereas, These medical students completed their premedical collegiate training in the United States, and

Whereas, In a less competitive time, some or all of these students would have been admitted to a U. S. medical school, and

Whereas, The Council on Medical Education of the American Medical Association on June 20, 1971 adopted a policy statement which provides a new pathway for entrance to AMA-approved internship and residency programs for students in foreign medical schools, and

Whereas, The Council on Medical Education of the American Medical Association adopted guidelines on March 12, 1972 to assist in the development of programs to implement that policy, and

Whereas, 18 states accept the "Fifth Pathway" for licensure via State Medical Board policy, and

Whereas, An additional six states have laws that allow licensure via the "Fifth Pathway," therefore, be it

Resolved, That this House of Delegates of the Missouri State Medical Association strongly urges the State Board of Healing Arts o adopt the policy of accepting the "Fifth Pathway" for Missouri liensure, and be it further

Resolved, That copies of this resolution and attached guidelines e sent to all members of the State Board of Healing Arts and all medical school Deans and admissions officers of medical schools in Missouri.

(Attachment to Resolution #19)

GUIDELINES[*]

FOR A YEAR OF SUPERVISED CLINICAL TRAINING FOR SELECTED STUDENTS FROM FOREIGN MEDICAL SCHOOLS

Intent

These guidelines are intended to assist in the development of programs to implement the policy statement adopted by the Council on Medical Education on June 23, 1971. They are directed to medical schools which have elected, after an appropriate assessment of their resources, to offer the year of supervised clinical training. Therefore, hey apply to a program to assist students who have completed premedical requirements in the U. S., were qualified for but were unable o gain admission to a U. S. medical school, and who have completed all of the formal requirements of a foreign medical school except nternship and/or social service. Upon completion of the program, he student will be eligible for appointment to an approved internhip or residency.

Introduction

Each U. S. school must determine the eligibility of the individual candidate for admission into the year of supervised clinical training. The intent of the Council policy statement is that the selection procedure differentiate between students who, in a less competitive time, would have been admitted to a U. S. medical school from students who would not have been considered qualified on the basis of the usual criteria. The policy statement is applicable only to the first group.

Students to be considered for a year of supervised clinical training must possess a certificate stating the completion of the formal academic requirements of the foreign medical school. It may be assumed that those holding this certificate have not had the clinical experience afforded by the U. S. clinical clerkship and, therefore, they are not qualified to provide professional services. The year of supervised clinical training should be considered as remedial and should nclude instruction in history taking and physical diagnosis.

Recommendations

The following guidelines are recommended for the year of supervised clinical training.

1. The year of supervised clinical training must be under the sponsorship and supervision of a U. S. medical school which will assume responsibility for the program.
2. The U. S. medical school should have final responsibility for determining the criteria for admission to this program, the characteristics of the program itself, and its successful completion.
3. The policy statement refers to an academic year of clinical training. The medical school should determine the duration of its academic year.
4. The evaluation to determine eligibility for the program should nclude a review of the applicant's academic achievement and test results completed prior to his admission to the foreign medical school.
5. Evidence of completion of the formal academic curriculum of he foreign medical school should be obtained. Most foreign medical schools, after completion of the academic curriculum, award a certificate or diploma which is not the professional degree recognized by the ECFMG and is not the equivalent of the U. S.-M.D.
6. A screening examination must provide assurance, before admission to the program, that the applicant is qualified to begin the year of supervised clinical training. The ECFMG examination or other examinations approved by the Council on Medical Education may be used for this purpose. If the Council makes available a special examination for the evaluation of these students, it may be required before the entrance to the year of supervised clinical training.
7. The U. S. school should decide the propriety of conducting such a program side-by-side with its clinical clerkship programs or n an affiliated hospital not utilized for scheduled clerkships. This choice should be made after a recognition of the quite different background of the foreign students.
8. It is recommended that the competence of each accepted student be individually evaluated and that the clinical training correspond to the need of the individual student.
9. In view of the need of these students for a general experience, it is suggested that usually the year of supervised clinical training should include experience in each of the major clinical departments.
10. Recognizing that this program will require the expenditure of effort and money by the medical school, the student may be charged an appropriate fee.
11. In order to emphasize the educational nature of the experience for the student, and to clearly distinguish the year of supervised clinical training from an "externship," or an internship, it is recommended that the hospital should not be permitted to remunerate the student and that the student should not be permitted to accept any remuneration, from either the hospital or its medical staff, which could be construed as payment for house officer services.
12. The medical school should retain, as it does for its other students, appropriate records describing the qualifications for admission, the time and duration of participation, and the achievement of the student at the completion of the year of supervised clinical training. A determination should be made that the student is, or is not, competent to enter a program of graduate medical education.

(Referred to Reference Committee on Medical Education and Public Welfare.)

Resolution #20—Fluoridation of the Public Water Supplies

(Introduced by Greene County Medical Society)

Resolved, That the Missouri State Medical Association endorses Report A of the Board of Trustees, as attached.

(Attachment to Resolution #20)

REPORT OF THE BOARD OF TRUSTEES OF AMA

Report: A (C-74)

Subject: State on Fluoridation of the Public Water Supplies
Presented by: Richard E. Palmer, M.D., Chairman
Referred to: Reference Committee G (Harry L. Arnold, Jr., M.D., Chairman)

Few health measures have been accorded greater clinical and laboratory research, epidemiological study, massive clinical trial of total community populations, and public attention—both favorable and adverse—than the fluoridation of public water supplies.

In 1957 the American Medical Association issued a position statement on fluorides and public water supplies (based upon what was then known through trial and study). It is timely to update this statement, since there now exists extensive additional experimental, clinical, laboratory and epidemiological data, confirming the safety and efficacy of this important essential nutrient.

In evaluating these data, the AMA had directed major interest at the clinical effectiveness of fluoride in public water supplies; factors of safety; range of effectiveness, together with levels of toxicity or other undesirable effects. The mechanics and control of the addition or removal of fluorides from water supplies have been reviewed. A complete understanding of the range of safety and effectiveness as it relates to the population as a whole, all ages and states of health, has been recognized to be of primary importance.

The recommended optimum concentration of fluoride in the water supply (0.7-1.2 ppm according to locality) should be consumed throughout life. This conclusion is based on epidemiological studies conducted in areas where fluoride occurs naturally in the water, and in areas where it has been added at the recommended level by mechanical means. Numerous controlled fluoridation programs, some in operation since 1945, have been evaluated as successful in reducing and/or preventing dental caries.

Only when relatively large amounts of fluoride (8-20 mg/day) are ingested over periods of 10 to 20 years are any generalized adverse effects encountered. No adverse effects have been reported when water containing optimum levels of fluoride has been drunk during periods of 10 to 20 years. Fluoride-induced mottling of tooth enamel has been reported only when fluoride concentration in the water exceeded 1.4 to 1.6 ppm.

Research has established that people consuming water containing the optimum level of fluoride experience no adverse effects on their kidneys, thyroid glands, reproductive functions, growth, development, blood, urine or hearing. No cases of allergic reactions have been linked with consumption of water fluoridated at the recommended levels.

Research has also provided evidence that suitable amounts of fluoride may be helpful in preventing or alleviating bone diseases such as osteoporosis, especially in our aging population.

Equipment has been developed, reliable analytical procedures are available, and appropriate safeguards have been established to assure that fluorides can be safely added to public water supplies at the optimum level.

The AMA has critically reviewed this subject in its entirety. It has taken cognizance of what has been done, as well as carefully weighing the comments and the scientific evidence of those who oppose fluoridation, in order to maintain an objective attitude concerning this important health measure.

No other alternatives or techniques for the provision of fluorides can at present replace the fluoridation of drinking water as an effective and practicable public health measure. When water fluoridation is not feasible, other means of supplying the proper amount of fluoride should be employed.

On the basis of this careful analysis of information, the AMA considers the fluoridation of public water supplies at the recommended rate to be a desirable and safe health measure for total populations, and urges all communities to take necessary actions.

(Referred to Reference Committee on Miscellaneous Affairs.)

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[*] Adopted by the Council on Medical Education of the American Medical Association on March 12, 1972.

Past House Action: C-57:66-67; C-56:110.

Resolution #21—Current Reports on PSRO Progress

(Introduced by Greene County Medical Society)

Resolved, That the Missouri State Medical Association and the American Medical Association provide for their members:

1. The documented positive accomplishments of the PSRO Advisory Committee and its task forces.
2. A progress report on the $1 million grant from HEW for specialty society "criteria" and the plan for the expenditure of the money.
3. A description of the amendments to the PSRO law, the number of the bills, their authors, and the plan of action for their passage.
4. A progress report on the "intense evaluation of the PSRO program."

(Referred to Reference Committee on Resolutions.)

Resolution #22—Priorities for Establishing a Rural Emergency Medical Services System

(Introduced by Greene County Medical Society)

Resolved, That the Missouri State Medical Association endorses Report J of the Board of Trustees, concerning Emergency Medical Services, as attached.

(Attachment to Resolution #22)

REPORT OF THE BOARD OF TRUSTEES OF AMA

Report: J (C-74)

Subject: Priorities for Establishing a Rural Emergency Medical Services System
Presented by: Richard E. Palmer, M.D., Chairman
Referred to: Reference Committee G (Harry L. Arnold, Jr., M.D., Chairman)

The Council on Rural Health and Committee on Community Emergency Services share a strong concern for developing and upgrading emergency medical services in rural areas. The Committee on Community Emergency Services works toward effective emergency medical services for all people. The Council on Rural Health aims to ensure availability and accessibility of health services, including emergency medical services, for persons residing and traveling in rural America.

With the current maldistribution of health manpower in rural areas, the problems of providing quality emergency medical services are difficult but not impossible. Although there may be only one, or possibly two, hospitals within a large geographic area, it is still possible to develop an emergency medical services system to meet the needs. Even though financial resources may be limited, public transportation may be non-existent, road networks may be limited, and the distances between medical resources may be great—rural America can and must receive adequate emergency medical care.

Components of Emergency Care System

There are four basic components to a good emergency care system:

1. Broad-based training for on-the-spot first aid;
2. A communications system that assures prompt response to the need;
3. Well-equipped emergency vehicles, staffed by emergency medical technicians—ambulance who are trained and equipped to provide all necessary life support at the scene and during transportation.
4. High quality emergency care facilities, staff, and equipment.

These four basic components must be coordinated, working together toward the single goal of quality care for the emergency victim.

Obviously, many communities today fall short of these standards. The reasons are legion: failure in any one of the components, fragmented efforts, lack of coordination, public or private apathy.

It is equally obvious that the first step in the development of an adequate emergency medical services system is to secure the cooperation and involvement of all appropriate community agencies and health facilities.

To the four basic components, therefore, must be added another:

5. A community council or emergency medical services council to bring together the leaders providing such care for planning, education, and funding

The Rural Situation

While the majority of the nation's population is urban in residence, the majority of highway fatalities are rural in occurrence. Rural roads and highways are the sites for about seven out of every ten traffic fatalities. The fatalities include both rural and urban residents who often die, not because of the irreversible severity of their injuries but because care is inadequate and not immediately available. More than 6,000 farm residents each year die as a result of farm, home and highway accidents. The growth of recreation centers and tourism in rural areas makes the problem more acute.

The Emergency Medical Services Systems Act of 1973 (P.L. 93-154) offers rural communities a major resource for establishing or upgrading emergency service programs. The Act authorizes the Secretary of HEW to make grants and enter into contracts with eligible entities for projects that include studying the feasibility of establishing emergency medical service systems, expansion or improvement of existing systems, and the initial operation of such a system. Of special significance is the provision that, for any fiscal year, not less than 20 percent of the grants and contracts shall serve rural areas.

Minimum Needs for a Rural EMS System

The Council on Rural Health and the Committee on Community Emergency Services recommend certain minimum needs for a rural emergency medical services system. These criteria have been developed for designating a rural hospital as an emergency facility:

(a) A two-way radio capable of contacting other hospitals and all emergency ambulances, with a trained staff available 24 hours a day.

(b) A nurse or physician's assistant, properly trained in emergency procedures, in the hospital and available to the emergency room 24 hours a day.

(c) Appropriate protocols to cover emergency activities while the physician is enroute to the hospital.

(d) A physician trained in emergency medicine on call or in the hospital 24 hours a day and available within 15 minutes.

(e) Laboratory and X-ray film technicians available in the hospital or on call and accessible within 30 minutes, 24 hours a day.

(f) Minimal equipment, including examining tables with safety belts, laryngoscope, oxygen, suction, resuscitation, splints, sutures, cardiac emergency equipment, and an incubator.

(g) An active emergency department committee that meets at least four times a year with authority to review operations and make recommendations.

(h) Proper signs identifying the location of the hospital, and proper signs and arrows pointing to the location of the emergency center within the hospital.

(i) A formal plan for primary coverage at all times by physicians who can carry out certain basic coverage and for back-up specialists.

(j) A formal plan readily available in the emergency room covering the types of patients to be provided with basic emergency care only and transferred, necessary procedures and arrangements to be made with ambulance and other emergency transfer personnel and with the hospital to receive the patient. A patient record outlining problems and treatment shall accompany the patient during transfer.

(k) A record of patient problems, care, and outcome that allows easy and comprehensive review.[1]

The AMA publication entitled "Categorization of Hospital Emergency Capabilities"[2] offers some guidelines to help the hospital establish effective emergency medical care in the emergency department.

Local Approach

The Council on Rural Health and the Committee on Community Emergency Services urge state and county medical societies to encourage rural communities to:

1. Organize a rural emergency medical services system which will include a rural hospital within the area.
2. Be informed and consider the feasibility of utilizing the resources available through the Emergency Medical Services Systems Act of 1973 (P.L. 93-154). The federal agency responsible for administration of the law is HEW's Department of Emergency Medical Services.

References:

1. Julian A. Waller: "Urban-Oriented Methods—Failure to Solve Rural Emergency Care Problems," JAMA 226:1441-1446, Dec. 17, 1973.

2. "Categorization of Hospital Emergency Capabilities," American Medical Association, Chicago, 1971, 33 pp.

(Referred to Reference Committee on Miscellaneous Affairs.)

Resolution #23—Licensing Power of the Missouri State Board of Healing Arts

(Introduced by the Greene County Medical Society)

Resolved, That the Missouri State Medical Association opposes any legislation which dilutes the licensing power of the Missouri State Board of the Healing Arts and encourages the passage of such laws as will aid the Missouri State Board of Healing Arts to license those physicians of ethical and moral character.

(Referred to Reference Committee on Miscellaneous Affairs.)

Resolution #24—Advertising: Physicians and Prepaid Medical Care Plan

(Introduced by Greene County Medical Society)

Resolved, That the Missouri State Medical Association asks for clarification of Report B of the AMA Judicial Council as follows:

Advertising, Physicians and Health Maintenance Organizations, nd Health Plans

It is not unethical for a physician to provide medical services to nembers of a prepaid medical care plan or to members of a health naintenance organization which seeks members (or subscribers) hrough advertising its services, facilities, charges or other nonpro-essional aspects of its operation as long as such advertising does not dentify, refer to or make any qualitative judgement concerning any hysician who provides service to the members or subscribers.

(Referred to Reference Committee on Resolutions.)

Resolution #25—Community Medical Directories

(Introduced by Greene County Medical Society)

Resolved, That the Missouri State Medical Association endorses Report C of the AMA Judicial Council as follows:

Community Professional Directories

> It is not unethical for a physician to authorize the listing of his name and practice in a directory for professional or lay use which is intended to list all physicians in the community on a uniform and nondiscriminatory basis. The listing shall not include any self-aggrandizing statement or qualitative judgement regarding the physician's skills or competence. The *American Medical Directory* provides an example of the kind of information that may be properly listed in national as well as community directories for health service personnel. Likewise, specialties or specialty practices used in the *American Medical Directory* should set the pattern for specialty designations.

(Referred to Reference Committee on Constitution and Bylaws.)

Resolution #26—Third Party Payers

(Introduced by Greene County Medical Society)

Whereas, The following quotation appeared in a letter from Blue Cross in Montana to a Medicare beneficiary:

> "However, it has also been determined that you, the beneficiary, had no knowledge or any way of knowing that the services received during that time were not medically necessary," and

Whereas, The one using such language was not in attendance at he time the services were rendered and his conclusion is in retro-pect, after the patient has recovered, and not based on personal ob-ervations at the time; and

Whereas, His indication to the patient that the services were not nedically necessary often overrules the local review committee, gain in retrospect and without any personal contact; and

Whereas, Such language encourages patients to decline to pay or services rendered in good faith and on the basis of the situation hen existing; and

Whereas, Such language fosters malpractice litigations, since it s stated as an absolute and unrebuttable conclusion; and

Whereas, The publication thereof is defamatory to the attending hysician, constitutes libel and is perhaps libelous per se; therefore, e it

Resolved, That the Missouri State Medical Association expresses ts extreme dissatisfaction with and strenuous objection to the above anguage use in Third Party payers in denying benefits to patients.

(Referred to Reference Committee on Resolutions.)

Resolution #27—Patient Education

(Introduced by Greene County Medical Society)

Whereas, Patient education is the process whereby patients and/ r those nonprofessionals responsible for their care are taught their oles in the maintenance of health and the treatment of disease and re motivated to carry out their identified responsibilities; and

Whereas, Effective patient education programs are based upon he unique needs of the patient and the resources of the health pro-essionals concerned and such programs should be provided by rained educators and directed toward improving health through the ooperative efforts of the patient and health professionals; and

Whereas, Patient education should be an integral part of quality ealth care to be established, maintained and evaluated by the ealth professionals involved and by the institutions and organiza-ions they represent according to appropriately established standards f quality, delivery, utilization and cost; and

Whereas, Payment for qualified programs appropriate to the ealth needs of the patient is, therefore, a legitimate health care cost; herefore, be it

Resolved, That the Missouri State Medical Association adopts the following guidelines for third party reimbursement for patient education:

1. The goal of patient education programs shall be to improve health and the delivery of health care services through cooperative efforts of informed patients and health professionals.
2. Patient education programs shall be provided under the guidance of an educational committee comprised of members of the health professions, and administration, and consumers.
3. Patient education committees will be responsible for the establishment, maintenance, and evaluation of all patient education programs.
4. Patient education services shall consist of planned efforts, with stated goals and objectives, based upon identifiable needs of patients and the resources of the health professionals.
5. Patient education services shall be provided under the direction of a practicing physician and a trained educator and must be appropriate to the immediate health needs of the patient.
6. Participation in such programs shall be by prescription of a practicing physician and shall be documented in the patient's chart.

(Referred to Reference Committee on Miscellaneous Affairs.)

Resolution #28—Physician's Assistants

(Introduced by Greene County Medical Society)

Whereas, The use of physician assistants by primary physicians and the use of specialty assistants trained under guidelines of their respective specialties is favored where the use of such assistants will greatly increase the availability and quality of medical care, and

Whereas, The Missouri State Medical Association encourages the development of training programs for physician assistants under guidelines of accreditation as prepared by the American Medical Association and favors passage of such legislation which will place control of physician assistants under the Missouri Board of Healing Arts, and

Whereas, There have been attempts by professional groups not medically trained to amend such controlling legislation to exclude physician assistants of some specialty groups of physicians, and

Whereas, These amendments would lead to reduced availability of needed medical care for the people of Missouri; therefore, be it

Resolved, That any attempt to amend the physician assistant training act to exclude or limit physician assistants in any phase of medicine or surgery be resisted with all possible effort of the Missouri State Medical Association and organized medicine.

(Referred to Reference Committee on Miscellaneous Affairs.)

Resolution #29—Task Force Report on Foreign Medical Graduates

(Introduced by Greene County Medical Society)

Whereas, Previous so-called Foreign Medical Graduates reports have neither included house staff nor Foreign Medical Graduate input, and

Whereas, These reports have promulgated racist and jingoistic concepts and profoundly influenced pending legislation, and

Whereas, These reports, if implemented, will exacerbate inner-city health manpower problems, and

Whereas, The Committee on House Staff Affairs Task Force Foreign Medical Graduates has prepared a thorough, well-documented report from both House Staff and Foreign Medical Graduates sources, therefore, be it

Resolved, That the AMA Report on Foreign Medical Graduates be published in Missouri Medicine, and be it further

Resolved, That all members of the Missouri State Medical Association study the report on Foreign Medical Graduates.

(Referred to Reference Committee on Medical Education and Public Affairs.)

Resolution #30—Uniform Insurance Claim Form

(Introduced by Greene County Medical Society)

Whereas, The Council on Medical Services of the AMA has developed the Uniform Health Insurance Claim Form dated October, 1973, and

Whereas, The Uniform Health Insurance Claim Form is a first step toward the reduction of processing time, processing costs of such Health Insurance Claim Forms, and

Whereas, The reverse side of this claim form contains the following affidavit to be attested by the physician:

Signature of Physician or Supplier

> "I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally rendered by me or under my direction. I understand that payment of this claim may be from Federal or State funds and that, in that event, any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws. I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the state's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the state agency may request. I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductibles and co-insurance."

Whereas, The above mentioned affidavit is unacceptable and demeaning to physicians, therefore, be it

Resolved, That the Missouri State Medical Association rejects the affidavit on the Uniform Insurance Claim Form.

(Referred to Reference Committee on Resolutions.)

Resolution #31—Evaluation of Competency

(Introduced by Greene County Medical Society)

Whereas, Proposals for national licensure and periodic relicensure of physicians are now being advanced in the Congress, and

Whereas, Several states have already enacted medical relicensure statutes, and

Whereas, Most specialty boards are not in the process of developing recertification procedures, and

Whereas, The art and skills of experienced practitioners within the boundaries of their self-defined limits of practice cannot be properly evaluated by standardized examinations of cognitive information, and

Whereas, Precipitate, ill-advised measures intended to maintain professional competence co-produce diversions of health manpower counterproductive of the desired benefits, therefore, be it

Resolved, That well-designed methods of professional peer review emphasizing evaluation of performance rather than the ability to score on examination of knowledge be endorsed as the best means of appraising competence in providing medical care, and be it further

Resolved, That the Board of Trustees refer this matter to the appropriate committee or council to prepare guidelines to implement this objective.

(Referred to Reference Committee on Medical Education and Public Welfare.)

Resolution #32—Blue Cross Reimbursement to Surgicenters

(Introduced by Greene County Medical Society)

Whereas, The standard Blue Cross contract equates ambulatory surgical care facilities with hospitals by reimbursing on a "cost-plus five percent" basis, and

Whereas, The "Cost-plus" concept is notorious for resulting in inefficiency, poor management and dubious bookkeeping procedures, and

Whereas, Ambulatory surgical care facilities have demonstrated their ability to effect cost savings in health care delivery through sound management and less costly outpatient service, therefore, be it

Resolved, That the Missouri State Medical Association urges all Blue Cross plans using the "cost-plus" concept in contracts with ambulatory surgical care facilities to delete this requirement, and be it further

Resolved, That the Missouri State Medical Association initiates appropriate legislation prohibiting this unfair practice wherever it exists.

(Referred to Reference Committee on Resolutions.)

Resolution #33—Federally-Imposed Requirements on Medical Schools, Federal Licensure or Relicensure or Federal Certification or Recertification of the Medical Specialties of Physicians

(Introduced by Greene County Medical Society)

Whereas, There have been considered in the 93rd Congress, Second Session, a number of legislative proposals that would give the federal government unwarranted and dictatorial authority over the assignment of physicians to geographical locations, the numbers and location of all resident training, the delivery of professional medical care and medical education, and

Whereas, Such legislative proposals have ranged from declaring medicine to be a national utility—to requiring two years of involuntary servitude for *all* medical school graduates—to federal licensure and relicensure and to federal certification and recertification examinations in each medical specialty—to federal control of all internships, residency training programs, *et al,* and

Whereas, The present state of the nation clearly demonstrates that federal control brings chaos; witness the nation's critical food supply in spite of decades of federal control of crops and foods; witness the nation's critical energy shortage in spite of decades of federal control of energy; witness the chaotic and nearly bankrupt nationwide transportation systems in spite of decades of federal control of interstate transportation; witness the chaos of the federally controlled patient-care programs of the Indian Health Service *et al,* therefore, be it

Resolved, That the Missouri State Medical Association instructs its members to oppose without equivocation any and all proposed congressional legislation and all proposed federal regulations that would:

1. Impose on medical schools any requirements, by law or by regulation, that would force said medical schools to accept students on any basis or consideration other than the personal and academic qualifications of each applicant.
2. Oppose any and all legislative or regulative efforts that would give federal controls over the numbers, locations, types, and continuity of medical training programs, including undergraduate, postgraduate and continuing medical education programs.
3. Impose student quota requirements and/or type of practice and location of practice requirements as a contingency for receiving federal funds.
4. Attempt or seek to attempt to impose any federal licensure or relicensure or federal certification or recertification or the medical specialties of physicians.
5. Weaken or otherwise subjugate the present state licensing board system of licensure examination of, by and for peers in medicine.
6. Attempt or seek to attempt to deprive a citizen of his Constitutional rights to apply for and be accepted or rejected by a medical school solely on the basis of his individual qualifications or deprive him of personally selecting his type of medical practice or deprive him of selecting his location of medical practice.
7. Impose on medical students and physicians any type of involuntary servitude, and be it further

Resolved, That the Missouri State Medical Association hereby urges all members and all medical specialty societies to oppose with equal vigor any legislative attempts, be they federal or state, to gain lay control over medical education and the medical profession, and be it further

Resolved, That the Missouri State Medical Association in timely fashion, participates in the formulation of positions on issues of medical interest, and be it further

Resolved, That the Missouri State Medical Association, in timely fashion, contacts members of the Congress with respect to this legislation, beginning at the time the legislation is initially introduced and extending through all stages of transit through Congress.

(Referred to Reference Committee on Miscellaneous Affairs.)

Resolution #34—Interest Charged on Unpaid Accounts

(Introduced by Greene County Medical Society)

Resolved, That the Missouri State Medical Association endorses Report D of the AMA Judicial Council, which says in part:

> Since the practice of medicine is a profession and not a business, the practices adopted by businesses are not necessarily suitable to medicine. It is not in the best interest of the public or the profession to charge interest on an unpaid bill or note for professional services not paid within a prescribed period of time nor is it proper to charge a patient a flat collection fee if it becomes necessary to refer the account to an agency for collection.
>
> Despite requests to modify or rescind this opinion, the Council has no information or data which would indicate that charging interest reduces the physician's accounts receivable or materially changes a patient's paying habits. In view of this, the Council affirms its 1962 opinion regarding interest charges and flat collection fees.
>
> It is not improper, however, for a physician to add a service charge equal to the actual cost of rebilling on accounts not paid within a reasonable time. Patients must be notified in advance about the existence of this practice.

(Referred to Reference Committee on Resolutions.)

The Speaker then reminded the delegates that, according to the Constitution and Bylaws, introduction of new resolutions not included in the Delegates Handbook would be in order at the Second Session of the House provided that 200 copies of the resolution or funding for same are made available and presented to the delegates 24 hours before the meeting, that ten copies be submitted to the Secretary and that introduction of each resolution is approved by a two-thirds vote of the House of Delegates.

The Speaker introduced Dr. Hubert A. Ritter who commented on the expectation that at the AMA Clinical Convention in Atlantic City in June, the AMA House of Delegates will accept the invitation to hold the 1978 AMA Annual Session in St. Louis. He said that this would be the first meeting of the AMA in St. Louis since the Clinical Convention was held there in 1962, and he expressed appreciation for the cooperation received from the St. Louis Convention and Tourism Bureau.

There being no additional business, the Speaker declared the first session of the House of Delegates adjourned.

SECOND SESSION

Friday, April 18, 1975

The Second Session of the House of Delegates was called to order at 4 PM by Dr. Robert A. Slickman, Speaker, who presided.

Dr. Gulick, chairman of the Credentials Committee, reported that a quorum was present.

The Speaker invited Dr. James E. Campbell, Chairman of the Reference Committee on Miscellaneous Affairs, to make his report.

MISCELLANEOUS AFFAIRS

The Reference Committee on Miscellaneous Affairs met in the Park Plaza Hotel in St. Louis, Missouri at 3:30 PM on April 17, 1975. The entire Committee was present as assigned, with James E. Campbell as Chairman, presiding. Open discussion was held until 4:15 PM. The Committee then met until 4:45 PM.

The Committee considered the portions of the Council minutes referred to it for the Council meetings of May 25, 1974; September 14, 1974; December 14, 1974; February 8, 1975; April 16, 1975. In the discussion of the Council's resolution at the April 16 meeting regarding the MSMA opposition to administrative interference with the **Board of Healing Arts,** it was further recommended that a copy of the resolution be sent to the legislature and to the Governor and, also, to all the media.

(The motion to adopt was approved.)

The Committee considered the report submitted by the Commission on Public Affairs and recommended the adoption of this portion of the report.

Mr. Speaker, I move the adoption of this portion of the report.

(The motion to adopt was approved.)

Resolution #7—Gov. Christopher S. Bond

Resolution #8—Herbert R. Domke, M.D., Director Missouri Division of Health

The Committee considered Resolution #7 and Resolution #8 and recommended the referral of these Resolutions to the Legislative Committee.

Mr. Speaker, I move the adoption of this portion of the report.

(The motion to refer was approved.)

Resolution #20—Fluoridation of the Public Water Supplies

The Committee then considered Resolution #20, which was introduced by the Greene County Medical Society. The Committee moved to approve this resolution as presented.

Mr. Speaker, I move the adoption of this portion of the report.

(The motion was approved.)

Resolution #22—Priorities for Establishing a Rural Emergency Medical Services System

The Committee considered Resolution #22, which was introduced by Greene County Medical Society. The Committee recommended that Line 19 on page 3 be amended to read as follows:

> A physician on call or in the hospital 24 hours a day and available within 15 minutes.

The Committee recommended adoption of Resolution #22 as amended.

Mr. Speaker, I move adoption of this portion of the report.

(The Speaker called for a vote on the amendment to Resolution #22. The amendment was approved. The Speaker then called for a vote on Resolution #22 as amended. Resolution #22 as amended was not approved.)

Resolution #23—Licensing Power of the Missouri State Board of Healing Arts

The Committee then considered Resolution #23, which was introduced by Greene County Medical Society. The Committee recommended approval of this Resolution as presented.

Mr. Speaker, I move the adoption of this portion of the report.

(The Speaker called for a vote on Resolution #23. Resolution #23 was adopted.)

Resolution #27—Patient Education

The Committee considered Resolution #27, which was introduced by Greene County Medical Society. The Committee recommended approval of this Resolution as presented.

Mr. Speaker, I move the adoption of this portion of the report.

(After discussion, the Speaker called for a vote on Resolution #27. Resolution #27 was approved.)

Resolution #28—Physician's Assistants

The Committee considered Resolution #28, which was introduced by Greene County Medical Society. The Committee recommended approval of this Resolution as presented.

Mr. Speaker, I move the adoption of this portion of the report.

(The Speaker called for a vote on Resolution #28. Resolution #28 was adopted.)

Resolution #33—Federally-Imposed Requirements on Medical Schools, Federal Licensure or Relicensure or Federal Certification or Recertification of the Medical Specialties of Physicians

The Committee considered Resolution #33, which was introduced by Greene County Medical Society. The Committee moved that this resolution be approved as presented.

Mr. Speaker, I move the adoption of this portion of the report.

(The Speaker called for a vote on Resolution #33. Resolution #33 was approved.)

The Committee considered the report of the Committee on Legislative Affairs, pertaining to bills introduced in both Houses of the Missouri General Assembly. The Committee recommended approval of this report.

Mr. Speaker, I move the adoption of this portion of the report.

(The motion to adopt was approved.)

The Speaker invited Dr. E. J. Cunningham, Chairman, to present the report of the Committee on Constitution and Bylaws.

CONSTITUTION AND BYLAWS

The Reference Committee on Constitution and Bylaws met on Thursday, April 17, 1975, in the Chase Club of the Chase-Park Plaza Hotel in St. Louis after the session of the House of Delegates. All Committee members were present. The Committee recommends the adoption of the Council Minutes referred to this Committee. The Committee accepted the recommendations of the Supplemental Council report and awaits the comments and suggestions of our Insurance Underwriters prior to taking any such action on a statewide "Pre-Trial Screening Panel." The Committee recommends the acceptance of the report of the Medical-Legal Commission for information only.

Regarding the portion of the report concerning Missouri State Medical Insurance, Inc. (MSMI, Inc.), the Committee moves the acceptance of two motions previously approved by the Council:

1. That the Council give the three MSMA directors on the MSMI Board—Drs. McAlhany and Clark and Mr. Royal O. Cooper—the authority to vote MSMA shares at any properly called meeting.
2. That the Council authorize the purchase of 200 shares of MSMI, Inc., stock at $10 per share.

Mr. Speaker, I move that this portion of the report be accepted.

(The motion carried.)

The Committee recommends that the portion of the report of the Commission on Medical-Legal Affairs regarding "Pre-Trial Screening Panels" be received for information only. After some discussion the Committee felt that this issue had been covered in the Supplementary Report of the Council, April 16, 1975, that was previously accepted.

Mr. Speaker, I move that this portion of the report be accepted.

(The motion carried.)

The Committee accepted the report of the Ad Hoc Committee on Group Professional Liability Insurance and recommended official commendation to Dr. Irvin H. Clark, Chairman, and his Committee for their efforts that have produced such effective results.

Mr. Speaker, I move the acceptance of this portion of the report.

(The motion carried.)

Resolution #3—Establishment of a Professional Liability Committee

Mr. Speaker, the committee recommends that Resolution #3 not be adopted. This had been discussed previously and action was taken by the Council as reported in its Supplemental Report of April 16, 1975, which was accepted in the earlier portion of this report.

(The Speaker read the Resolve *of Resolution #3, as follows:*

Resolved, That the House of Delegates of the Missouri State Medical Association goes on record as recognizing the need for the establishment of a Professional Liability Committee both on a state and local level, to screen malpractice claims. Such a Committee should work in conjunction with the insurance carriers and representatives of the legal profession and to seek the establishment of remedies in the area of malpractice claims.

The Speaker then called for a vote on Resolution #3. Resolution #3 was not adopted.)

Resolution #9—Professional Liability Legislation

The Committee recommends that Resolution #9 not be adopted inasmuch as these issues were previously approved in the MSMA Council Minutes of Feb. 8, 1975 and previously accepted by this body.

Mr. Speaker, I move that this portion of the report not be accepted.

(The Speaker called for a vote on Resolution #9. Resolution #9 was not adopted.)

Resolution #13—Action on Professional Liability

Mr. Speaker, the Committee moves that Resolution #13 not be adopted in view of the prior action of the Council Minutes regarding professional liability.

Mr. Speaker, I move that this portion of the report not be accepted.

(The Speaker called for a vote on Resolution #13. Resolution #13 was not adopted.)

Resolution #14—Contingent Fee System

The Committee recommends that Resolution #14 not be adopted because of our prior action regarding Council minutes of Feb. 8, 1975.

(The Speaker called for a vote on Resolution #14. Resolution #14 was not adopted.)

Resolution #18—Malpractice Crisis-No-Fault Insurance

The Committee recommends that Resolution #18 not be adopted. The Committee felt that No-Fault Insurance is not the solution to the medical liability problem.

Mr. Speaker, I move the adoption of this portion of the report.

(The Speaker called for a vote on Resolution #18. Resolution #18 was not adopted.)

Mr. Speaker, the Committee recommends acceptance of that portion of the report of the Committee on Constitution and Bylaws regarding a Vice-Councilor in each district and accepts the recommendation that the MSMA Council adopt its own mechanism to provide for someone to represent the Councilor District in the absence of the elected Councilor.

Mr. Speaker, I move the acceptance of this portion of the report.

(The motion carried.)

MSMA Parliamentary Procedure
(Resolution #5—1974)

The Committee recommends adoption of that portion of the report of the Committee on Constitution and Bylaws regarding Resolution #5, which was introduced in the 1974 House of Delegates. The Committee moves that the House of Delegates adopts the Sturgis Standard Code of Parliamentary Procedure in lieu of Roberts Rules of Order and recommends the following change in the Bylaws:

Chapter X. Rules of Order. The deliberations of this Association shall be conducted in accordance with parliamentary usages as defined in Sturgis Standard Code of Parliamentary Procedure.

Mr. Speaker, I move acceptance of this portion of the report.

(The Speaker stated that Resolution #5, which was introduced at the 1974 House of Delegates, requires a change in the Bylaws and would be held over until the House of Delegates session on April 20, 1975 as required by the Bylaws.)

Resolution #25—Community Medical Directories

The Committee recommends adoption of Resolution #25.

Mr. Speaker I move the adoption of this portion of the report.

(The Speaker called for a vote on Resolution #25. Resolution #25 was adopted.)

Reconsideration of
Resolution #40—Unified Membership of the MSMA With the American Medical Association (1974)

The Speaker recognized Dr. James Hasek of Mountain Grove.

Dr. Hasek stated that he had voted with the majority in opposition to Resolution #40 at the House of Delegates ession on Thursday, April 17 and he wished to change his vote. He moved that Resolution #40 be reconsidered by the House with a limiting motion that would make it effective or a period of three years only.

Resolution #40 reads as follows:

Resolution #40—Unified Membership with the American Medical Association

Whereas, The American Medical Association, a federation of state medical associations, is dedicated to acting in the best interests of all physicians; and

Whereas, The states of Arizona, California, Hawaii, Illinois, Okahoma, New York and Wisconsin have voluntarily recognized that he strength of our federation is measured by our degree of unity by establishing constitutional policies for unified membership; and

Whereas, The AMA provides services to all state medical associations on an appeal basis without regard to the number of state members who support the AMA through membership; and

Whereas, The AMA House of Delegates at the Clinical Meeting n November, 1972 adopted the policy, "that all state medical associations should be considered having all members support all levels for our national federation by adopting, where possible, the unified concept"; therefore be it

Resolved, That changes in the Bylaws of the MSMA be considered to the effect that all members of the Association shall also be members of the AMA, and be it further

Resolved, That the Council of the MSMA be instructed to assure hat full and ample discussion of this important issue occur in each of the Councilor Districts and each of the county societies to the end hat this Resolution in a formal manner be brought before the House of Delegates at the first session of the 1975 Annual Meeting of this Association.

(Dr. Hasek's motion to reconsider Resolution #40 at this ime was seconded. The Speaker noted that both Dr. Hasek's motion to reconsider and the main motion or resoution were now debatable. He requested that the Delegates confine discussion to Dr. Hasek's motion to reconsider.

A delegate rose to a point of order, questioning the legitimacy of reconsideration of Resolution #40. The Parliamenarian ruled that the motion was in order since it was introduced by a delegate who had voted with the majority at the first session of the House.

A discussion of Resolution #40 followed. The general eeling was that the vote against adoption of Resolution #40 was not a vote against the American Medical Associaion, but was in objection to "mandatory" membership in he AMA. It was generally expressed that membership in he AMA is of prime importance at this time and that the AMA should be supported by MSMA members but on a voluntary rather than a compulsory basis.

Dr. Ernest Wadlow, St. Joseph, called for the question which was the motion to reconsider Resolution #40. The Speaker called for a voice vote, stating that this motion required a simple majority for approval. Since the voice vote was not definitive, the Speaker called for a standing vote. The motion to reconsider Resolution #40 was approved.

There was extensive discussion about Resolution #40. The Speaker invited Dr. Hasek to introduce his proposed amendment to Resolution #40.

Dr. Hasek moved that the first Resolve *in Resolution #40 be amended by adding the words "for a period of three years" as follows:*

Resolved, That changes in the Constitution and Bylaws of the Missouri State Medical Association be considered to the effect that ll members of the Association shall also be members of the Amerian Medical Association for a period of three years.

Dr. Hasek's motion was seconded. Additional discussion ollowed. A delegate inquired as to when Resolution #40 would become effective if it were approved. Dr. Hugh Riter, author of the resolution, explained that it would become effective in 1976.

After further discussion, the Speaker called for a voice vote on the amendment to Resolution #40. The vote was not definitive. The Speaker called for a standing vote. The amendment to Resolution #40 was adopted by a simple maority.

After more discussion of Resolution #40 as amended, Dr. E. J. Cunningham called for the question. The Speaker instructed the House that a two-thirds majority vote would be required for approval of Resolution #40 as amended since it requires a change in the MSMA Constitution and Bylaws. He called for a standing vote. The vote was 88 for and 83 against, and Resolution #40 failed.)

The Speaker invited Dr. Harry S. Jonas, Chairman, to present the report of the Reference Committee on Resolutions.

RESOLUTIONS

The meeting of the Reference Committee on Resolutions was held at 4 PM in the Coach Room, Chase-Park Plaza Hotel on April 17, 1975. All members of the Committee were present with the exception of Dr. King.

The Reference Committee gave careful consideration to the several items referred to it and submits the following report:

The Council Minutes assigned to the Resolutions Committee were reviewed by the Committee. They included the meetings of May 25, 1974, Sept. 14, 1974 and Feb. 8, 1975. These Minutes were reviewed and approved by the Committee.

The Annual Report of the Health Care Foundation of Missouri and HCFM/PRSO Support Center was referred to the Committee for information only. This report was reviewed and duly noted by the Committee.

The Supplementary Report of the Council was referred to the Reference Committee on Resolutions for review, having been presented before the House of Delegates on April 17, 1975. This portion of the Supplementary Report was approved by the Committee.

The Report of the Commission on Medical Economics, Third Party Medicine and Governmental Relations was reviewed and the Resolutions Committee recommends adoption of this report.

Mr. Speaker, I move acceptance of this portion of the report.

(The motion carried.)

Resolution #11—Politics in VA Hospitals

Resolution #12—Apply PL 92-603 (Section 249F) to Government Hospitals in Missouri

The Resolutions Committee next considered Resolution #11 and Resolution #12. These were introduced by Richard Bradley, M.D. and the St. Louis Medical Society. These two resolutions were introduced and unanimously accepted at the MSMA 1974 House of Delegates Meeting. Resolution #11 addresses itself to political interference in the operation of VA Hospitals. Resolution #12 asks that Public Law 92-603 be implemented in federal hospitals in the state of Missouri for a two-year trial period to be made public at the end of two years.

Your Reference Committee recommends that Resolution #11 be adopted as amended as follows:

Line #5 should read: "Public Law 92-603; and was signed into law."

Line #34 should read: "Officers and trustees of appropriate medical organizations."

Lines #35 through #40 should be deleted.

Resolution #11 as amended would read as follows:

Whereas, The Senate of the United States passed Public Law 92-603; and

Whereas, The House of Representatives of the United States passed Public Law 92-603; and was signed into law; and

Whereas, Section 249F of Public Law 92-603 relieves the legislative branch of the government from any utilization review in public and private hospitals by placing said responsibility with the department of HEW; and

Whereas, The Senate and House of Representatives have long been encumbered with frequent patient and Veterans representative requests to intercede in matters pertaining to medical care in Veterans Hospitals; therefore be it

Resolved, That all requests by patients and Veterans' representatives, rendered to Senators, or Representatives, or their staff, personnel, be sent direct to the department of HEW without benefit of a personal form letter answer from the legislator to the patient or his Veterans' representative, and be it further

Resolved, That the House of Delegates of MSMA direct the Missouri delegates to the AMA to place this resolution before the next session of the AMA House of Delegates for action at a National level and, be it further

Resolved, That the Speaker of the House of Delegates direct the MSMA staff to send copies of this resolution without delay to: The Governor and the Legislature of Missouri, Senators and Representatives from Missouri in the Congress of the United States, Officers and trustees of appropriate medical organizations.

Mr. Speaker, I move the adoption of this portion of the report.

(The Speaker called for the vote on Resolution #11 as amended and Resolution #11 was adopted as amended.)

The Committee recommends that Resolution #12 be adopted as amended, as follows:

Lines #46 and #47 are to be deleted.

Line #49—Item #4 becomes Item #3.

Line #53—Item #5 becomes Item #4.

Line #57 should read: "Officers and trustees of appropriate medical organizations."

Lines #58 through #63 should be deleted.

Resolution #12 as amended would read as follows:

Whereas, Section 249F, PL 92-603 was approved by the Senate, House of Representatives, and signed into law September 30, 1972 as a cost containment measure for medical services rendered to persons under Social Security, and

Whereas, Section 249F, PL 92-603 contains the implication that unnecessary medical services may be provided to persons under Social Security, and

Whereas, Section 249F, PL 92-603 ascribes to the Secretary of Health, Education and Welfare, unilateral authority to the survey of privileged communication between patients and their physician if the patient comes under Social Security, and

Whereas, Section 249F, PL 92-603 contains no contract responsibility on the part of the patient in contrast to minutely detailed contract responsibility for health care providers, and

Whereas, Conduct of Affairs stated in Section 249F, PL 92-603 would compromise the quality of medical care in favor of reducing the cost of medical care, and

Whereas, Application of the intent of Section 249F, PL 92-603 would cause physicians, hospitals and supporting specialities of the Private Sector to work out the errors and trials of this program, and

Whereas, The time required to experiment with the implementation of Section 249F. PL 92-603 would need to be subtracted from time spent in actual patient care, and

Whereas, The Department of Health, Education and Welfare lacks sufficient funds to implement the PSRO Program in those geographical areas selected by the Secretary, therefore be it

Resolved, That the House of Delegates of the Missouri State Medical Association, acting for the patients, physicians, hospitals, extended care facilities and supporting specialities who deliver or receive medical care under the auspices of Social Security or HEW, in Missouri

1. Request of the Social Security Administration and the Department of HEW, that Section 249F, PL 92-603 be applied in Government owned and controlled hospitals and extended care facilities now in operation in the State of Missouri for a period of two years.
2. Request of the Social Security Administration and Department of HEW, a report on this experiment publicly to the citizens of Missouri at the end of two years as to benefits derived and problems encountered.
3. Direct the Missouri delegates to the AMA to place this resolution before the next session of the AMA House of Delegates for action at a National level.
4. That copies of this petition be sent without delay to: The Governor of Missouri and the Legislature of Missouri, Senators and Representatives from Missouri in the Congress of the United States, Officers and trustees of appropriate medical organizations.

The Committee recommends that Resolution #12 be adopted as amended.

Mr. Speaker, I move the adoption of this portion of the report.

(The Speaker called for a vote on Resolution #12 as amended and Resolution #12 was adopted as amended.)

The Committee further recommends that the action called for in both Resolution #11 and #12 be fully implemented as soon as possible. The actions called for in both of thes resolutions, which were passed in 1974, were not implemented. Therefore, the Committee recommends that thi portion of the report be adopted.

Mr. Speaker, I move the adoption of this portion of thi report.

(The motion carried and this portion of the report wa adopted.)

Resolution #5—The Intent of Public Law 92-603

Resolution #17—PSRO

The Committee next considered Resolution #5, which wa introduced by Michael Murphy, M.D. and the St. Loui Medical Society, and Resolution #17, which was introduce by Leonard L. Davis, M.D. and the Audrain County Medical Society. These resolutions concern aspects of Publi Law 92-603.

Your Reference Committee on Resolutions believes tha the vast majority of physicians feel that Public Law 92-60 is not in the best interests of their patients and the practic of medicine. We, therefore, offer the following substitutio for Resolutions #5 and #17:

Whereas, The Congress of the United States has passed a law establishing professional standards review commonly know as PSRO and

Whereas, The original concept of Public Law 92-603 was t provide for a "grass roots" quality mechanism to the implemente by practicing physicians, and

Whereas, The present law vests all ultimate PSRO authority i the Secretary of the Department of Health, Education and Welfare and

Whereas, Certain rules and regulations promulgated under th authority of the Secretary are depriving PSROs of their "grass roots' character; now, therefore

Be it resolved, That the Secretary of the Department of Health Education and Welfare be advised of the subversion of the intent o Public Law Number 92-603 and that he be urged to advise members of his bureaucracy of the law intent of the law with regard t the local development of criteria and standards,

And, be it further resolved, That if control of PSRO is not returned to the local level as stipulated in the law, the MSMA will:

1. Promote nonparticipation in the program by the physicians o Missouri,
2. Institute appropriate legal actions and, if these are unsuccessful,
3. Work for the repeal of the law.

And, be it further resolved, That copies of this Resolution be sent to President Ford, the Secretary of HEW, U. S. Senators and members of Congress of Missouri, the AMA and the Missouri delegation to the AMA.

Mr. Speaker, the Resolutions Committee recommends the adoption of this Resolution as a substitute for Resolution #5 and #17.

Mr. Speaker, I move the adoption of this portion of the report.

(There was a brief discussion. Dr. Michael Murphy, author of Resolution #5, then withdrew his resolution in favor of the substitute Resolution recommended by the Reference Committee on Resolutions.

There being no further discussion, the Speaker called for a vote on the substitute resolution for Resolutions #5 and #17. The substitute resolution was adopted.)

Resolution #21—Current Reports on PSRO Progress

The Committee next considered Resolution #21 which was introduced by Greene County Medical Society. This resolution deals with dissemination of information regarding progress of PSRO.

Mr. Speaker, your Reference Committee recommends the adoption of Resolution #21.

(The Speaker called for a vote on Resolution #21. Resolution #21 was adopted.)

Resolution #10—Providing Up-To-Date Procedures for Checking on Patients' SSA Eligibility Status

The Committee next considered Resolution #10, which was introduced by Dr. Richard Bradley and the St. Louis

Medical Society. This resolution deals with the implementation of more efficient methods to obtain patients' SSA eligibility status.

Mr. Speaker, the Reference Committee recommends that Resolution #10 be adopted as amended:

Line #26—Delete the words "Department of." (SSA is not a department.)

Line #32—Insert "U. S." at the beginning of the line to refer to the United States Senators and Representatives rather than State.

Line #33 should read: "The officers and trustees of appropriate medical organizations."

Delete Lines #34 through #39, which name the organizations in the interest of brevity.

Mr. Speaker, I move the adoption of this portion of the report.

(The Speaker called for a vote on Resolution #10 as amended. Resolution #10 as amended was approved.)

Resolution #15—Development of Individual Practice Associations

The Committee next considered Resolution #15 which was ntroduced by the St. Louis Medical Society. This resoluion seeks to study the individual practice association as an alternative to HMOs.

Mr. Speaker, the Committee recommends that Resolution #15 be adopted.

(The Speaker called for a vote on Resolution #15. Resoution #15 was adopted.)

Resolution #24—Advertising: Physicians and Prepaid Medical Care Plan

The Committee next considered Resolution #24, which was introduced by Greene County Medical Society. This deals with the ethics of physicians' advertising when they are associated with health maintenance organizations and other health plans.

Mr. Speaker, the Committee recommends adoption of Resolution #24 as amended:

Line #2—Substitute the word "Reconsideration" for the word "Clarification."

Resolution #24, as amended reads as follows:

> *Resolved*, That the Missouri State Medical Association ask for reonsideration of Report B of the AMA Judicial Council as follows:
> Advertising, Physicians and Health Maintenance Organizations, nd Health Plans
> It is not unethical for a physician to provide medical services to members of a prepaid medical care plan or to members of a health maintenance organization which seeks members (or subscribers) hrough advertising its services, facilities, charges or other non-proessional aspects of its operation as long as such advertising does not identify, refer to or make any qualitative judgment concerning ny physician who provides service to the members or subscribers.

Mr. Speaker, I move the adoption of this portion of the eport.

(The Speaker called for a vote on Resolution #24 as amended. Resolution #24 was adopted as amended.)

Resolution #26—Third Party Payers

The Committee next considered Resolution #26, which was introduced by Greene County Medical Society. This esolution addresses itself to the use of language employed by third party payers in explanation of medical services.

Mr. Speaker, the Committee recommends that Resolution #26 be adopted.

(The Speaker called for a vote on Resolution #26. Resoution #26 was adopted.)

Resolution #30—Uniform Insurance Claim Form

The Committee now considered Resolution #30, which was introduced by Greene County Medical Society. This Resolution addresses itself to an unacceptable affidavit presently incorporated in the Uniform Health Insurance Claim Form.

Mr. Speaker, the Committee recommends that Resolution #30 be adopted.

(The Speaker called for a vote on Resolution #30. Resolution #30 was adopted.)

Resolution #32—Blue Cross Reimbursement to Surgicenters

The Committee considered Resolution #32, which was introduced by Greene County Medical Society. This resolution deals with the concept of reimbursement on a cost-plus-5% basis. Mr. Speaker, your Reference Committee recommends that this resolution be adopted.

(The Speaker called for a vote on Resolution #32. Resolution #32 was adopted.)

Resolution #34—Interest Charged on Unpaid Accounts

The Committee next considered Resolution #34, which was introduced by Greene County Medical Society. This resolution proposes that the Missouri State Medical Association endorses a recent report of the American Medical Association Judicial Council which states that interest charges on unpaid bills are unethical, but that a service charge for actual cost of rebilling is acceptable.

Mr. Speaker, the Resolutions Committee recommends that Resolution #34 be adopted.

(The Speaker called for a vote on Resolution #34. Resolution #34 was adopted.)

Resolution #2—Invasion of Patient Privacy by Governmental Agencies

The Committee considered Resolution #2, which was introduced by the St. Louis County Medical Society.

Your Reference Committee recommends that this Resolution be adopted as amended:

Line #2 should read as follows: "agencies and other third party payers to require physicians, hospitals and other providers of health care, et cetera"

Lines #14 and #15 should read as follows:

> *Resolved*, that the Missouri Medical Association and the American Medical Association continue to work in support of full confidentiality in patient record information.

Resolution #2 as amended reads as follows:

> Whereas, There have recently been attempts by various governmental agencies and other third party payers to require physicians, hospitals and other providers of health care to report information concerning diagnoses, procedures and other personal matters in a form which would make the individual patient easily identifiable; and
> Whereas, We feel that collection of such data represents a clear invasion of the patient's privacy and of the confidentiality of the patient-physician relationship; and
> Whereas, These efforts will undoubtedly increase if not challenged; now, therefore be it
> *Resolved*, That the Missouri Medical Association and the American Medical Association continue to work in support of full confidentiality in patient record information.

(The Speaker called for a vote on Resolution #2 as amended. Resolution #2 was adopted as amended.)

The Speaker invited Dr. Leo Wyrsch, Chairman, to present the report of the Reference Committee on Reports of Officers.

REPORTS OF OFFICERS

The Reference Committee on Reports of Officers met in the Colonial Room of the Chase-Park Plaza Hotel at 3:30 PM on Thursday, April 17, 1975 with all members present.

The remarks of the President, James C. Cope, M.D.; the President-Elect, R. Allen Chandler, M.D.; and the President of the Woman's Auxiliary, Mrs. George J. Lytton, were accepted and recommended for approval.

The reports of the Secretary, Treasurer and Executive Secretary were reviewed, accepted and recommended for approval.

The reports of the Committee on Planning and the Committee on Publications were reviewed and accepted.

Mr. Speaker, I move the acceptance of this portion of the report.

(The motion carried.)

The minutes of the Council Meetings from April 7, 1974; May 25, 1974; Sept. 14, 1974; Dec. 14, 1974; and the meeting of Feb. 8, 1975 were reviewed and accepted.

The Supplementary Report of the Council of April 16, 1975 also was reviewed and accepted. The Committee unanimously approved the motion of the Council that Dr. Joseph V. Finnegan of St. Louis be reappointed Editor of Missouri Medicine. The Committee also unanimously approved the motion of the Council that the present members of the Editorial Board and the Publications Committee be reappointed. The Committee also unanimously approved the motion of the Council for sponsorship of a trip to the South Pacific in January or February, 1976. The Committee also approved the motion of the Council that the MSMA extend sponsorship of a medical museum by the "Friends of Arrow Rock" and recognize this as a worthy endeavor.

Mr. Speaker, I move the adoption of this portion of the report.

(The motion carried.)

Resolution #4—Meeting of Component Medical Societies

The Committee next considered Resolution #4, the *Resolved* of which reads as follows:

> *Resolved*, That the House of Delegates of the Missouri State Medical Association direct the President to appoint an Ad Hoc Committee to organize a meeting of the representative of the component medical societies.

The Committee recommends that the *Resolved* be amended to read:

> *Resolved*, That the House of Delegates of the Missouri State Medical Association direct the President to appoint an Ad Hoc Committee to study the feasibility of a meeting of the representatives of the component medical societies.

Mr. Speaker, I move the adoption of this portion of the report.

(There was a discussion of the original and amended Resolve *in Resolution #4. Dr. Boles moved that Resolution #4 be rereferred to the Reference Committee on Reports of Officers for further consideration. His motion to rerefer Resolution #4 was approved.)*

The Chairman invited Dr. Thomas J. Cooper, Chairman, to present the report on the Reference Committee on Medical Education and Public Welfare.

MEDICAL EDUCATION AND PUBLIC WELFARE

The Committee on Medical Education and Public Welfare met at the Chase-Park Plaza Hotel in St. Louis on Thursday, April 17, 1975 at 3 PM. The Committee recommends that the reports of the council be accepted as published in the MSMA Journal from April through December, 1974, and also recommends approval of the reports o the council of February 8 and April 16, 1975.

Mr. Speaker, I move the adoption of this portion of th report.

(This portion of the report was adopted.)

The Committee reviewed the report of the Committee o Voluntary Health Agencies and accepted the report for information and continuing study. The Committee also reviewed the report of the Commission on Interspecialit Medicine and accepted it with commendation.

Mr. Speaker, I move the adoption of this portion of the report.

(This portion of the report was adopted.)

Resolution #1—Certificate of Birth

The Committee agrees in principle with Resolution #1 Because it was brought out in the discussion that there were legal requirements which had to be resolved, the Reference Committee recommends that it be referred back fo additional study to the Legal Counsel for the MSMA fo advice and requests that Resolution #1 be rereferred t the Commission on Medical-Legal Affairs.

Mr. Speaker, I move the adoption of this portion of the report.

(It was voted to rerefer Resolution #1 to the Commission on Medical-Legal Affairs.)

Resolution #16—Student Participation

The Committee recommends that Resolution #16 not be approved until further study is made of the financial consequences of such a worthwhile invitation.

Mr. Speaker, I move the adoption of this portion of the report.

(The Speaker called for a vote on Resolution #16. Resolution #16 was not adopted.)

Resolution #19—Tract V Program of AMA

The Committee recommends adoption of the Tract V Program as it is reported in Resolution #19.

Mr. Speaker, I move the adoption of this portion of the report.

(The Speaker called for a vote on Resolution #19. Resolution #19 was adopted.)

Resolution #29—Task Force Report on Foreign Medical Graduates

The Committee is in sympathy with Resolution #29, but on the advice of interested parties, we are told that the cost of reproducing this report in Missouri Medicine is prohibitive.

The Committee recommends that the essence of the report be distilled and that this be printed in Missouri Medicine.

Mr. Speaker, I move that this portion of the report not be adopted.

(The Speaker called for a vote on Resolution #29. Resolution #29 was not adopted.)

Resolution #31—Evaluation of Competency

The Committee recommends adoption of Resolution #31 with the exception that it be amended by striking the words

'Board of Trustees" and replacing them with the word 'Council."

(The Speaker called for a vote on Resolution #31 as mended by substitution. Resolution #31 as amended was dopted.)

Resolution—The Registered Nurse and Doctors' Phone and/or Verbal Medication Orders

The Committee reviewed the report of the Commission on Continuing Education and Health Manpower and accepted the report with the following amendment in Item #5 in he Resolution regarding "The Registered Nurse and Doctors' Phone And/Or Verbal Medication Orders":

#5. All emergency verbal and phone orders must be signed by a hysician or designated alternate as soon as possible.

There was a stipulation that this be done within 24 hours, out it was felt that this time frame was too restrictive.

Mr. Speaker, I move the adoption of this portion of the eport as amended.

(This portion of the report was adopted as amended.)

Resolution #6—Missouri Hospital Record Abstract Sheet

Resolution #6 produced a great deal of discussion among he people who were interested enough to attend the Reference Committee meeting. The concept of the Resolution s adopted in principle. However, it was felt that the consensus of opinion of those present, including the Director of he Division of Health of the state of Missouri, was that all nterested parties should be involved in producing a uniform eport suitable to the needs of the physicians, the hospital nd other interested third parties. It should be a single report that all would be able to use.

The intent of the Committee is that Resolution #6 be deeated as written, but that the report of the group that a ingle uniform report be used be accepted.

(The Speaker called for a vote on Resolution #6. Resoution #6 was not adopted.)

Mr. Speaker, I move the adoption of the report as a vhole.

(The Speaker called for a vote on adoption of the report s a whole. The report was adopted.)

The Speaker invited Dr. C. K. Fotopoulous to present the eport of the Reference Committee on Necrology.

NECROLOGY

The Reference Committee on Necrology met in the Khoassan Room of the Chase-Park Plaza Hotel on Thursday, pril 17, 1975.

The Reference Committee on Necrology of the Missouri tate Medical Association regretfully reports that there have een 88 deaths among members since the 1974 Annual Session, whose names are attached to this report. There is one ame to be added, Dr. Robert Parker of Kansas City. With his in mind, the Necrology Committee offers the following esolution:

Whereas, There have been 88 deaths among our members since he 1974 Annual Session, and

Whereas, Each of these members is missed as an individual as vell as for his contributions to the practice of medicine and to the lissouri State Medical Association, and

Whereas, The loss of each member is keenly felt by all members, is loved ones and close associates and, we are confident, the paients he has served with dedication, and

Whereas, Condolences in the form of the Memoriam Perpetuam as been sent to the immediate family of each deceased member, herefore be it

Resolved, That the same expression of sympathy continue to be sent to each immediate family and be it further

Resolved, That the House of Delegates now pay personal tribute by standing for a moment of silence in memory of each of the 88 members we have lost and whose names will be recorded in the minutes of this Annual Session.

Mr. Speaker, I move that the report of the Reference Committee on Necrology be approved.

(The motion was approved and the Speaker asked the members of the House of Delegates to stand for a moment of silence as indication of approval of the motion.)

Members Deceased Since the 1974 Annual Session

Raul Huet, M.D., Kansas City
Emmett J. Senn, M.D., Herculaneum
Frank S. Hogue, M.D., Kansas City
Richard Y. Kimura, M.D., St. Louis
A. N. Vaughn, M.D., St. Louis
Leonid Swidnicki, M.D., Bountiful, Utah
Edward P. Reh, M.D., St. Louis
Elmer J. T. Anderson, M.D., Montgomery City
Jack I. Kenzler, M.D., St. Louis
Earl G. Padfield, Jr., M.D., Kansas City
John H. Davis, M.D., Overland Park, Kansas
B. Albert Lieberman, Jr., M.D., Kansas City
Raymond A. Stansbrough, M.D., Normandy
Melvin E. Staehle, M.D., St. Louis
William J. Rutledge, M.D., Campbell
Donald M. Dowell, M.D., Chillicothe
Joseph Lederman, M.D., St. Louis
Howard Carter, M.D., Hamilton
Eugene M. Lucke, M.D., Hannibal
Albert M. Estes, M.D., Cape Girardeau
Sandor D. Papp, M.D., Joplin
John D. Maddox, M.D., Joplin
Charles A. Brasher, M.D., Mount Vernon
Thelma C. Buckthorpe, M.D., Sikeston
Arthur D. Knabb, M.D., Springfield
Robert F. Shaw, M.D., Liberty
Homer F. Mundy, M.D., St. Joseph
Grover B. Liese, M.D., Albuquerque, N. M.
Evan S. Connell, M.D., Kansas City
Solon P. Harris, M.D., St. Louis
Harry R. Echterhoff, M.D., Phoenix, Arizona
Helmuth H. Kramolowsky, M.D., St. Louis
Norman Tobias, M.D., St. Louis
Ben H. Brasher, M.D., Lexington
Lee W. Dean, Jr., M.D., St. Louis
Arthur E. Strauss, M.D., St. Louis
Girard A. Munsch, M.D., St. Louis
Esther E. L. Coffman, M.D., Lakeworth, Fla.
Richard W. Denney, M.D., Mountain Grove
Saul H. Maizus, M.D., St. Louis
Roger F. Christensen, M.D., Louisiana
Charles E. Nickson, Jr., M.D., Independence
Albert Preston, Jr., M.D., Kansas City
Paul C. Quistgard, M.D., Hollister
Hugh Ashley, Jr., M.D., Cape Girardeau
William R. Jackson, M.D., Maryville
Russell C. Porter, M.D., Long Beach, Calif.
Vincent L. Jones, M.D., St. Louis
Elmer G. Graul, M.D., St. Louis
Lilborn C. Boemer, M.D., St. Louis
William V. Koutsoumpas, M.D., St. Louis
Walter E. Koppenbrink, Jr., M.D., Higginsville
Joseph B. Guccione, M.D., St. Louis
Richard E. Hanna, M.D., St. Louis
Carl T. Rinker, Jr., M.D., Springfield
Francis J. Medler, M.D., St. Louis
Johnson Underwood, Jr., M.D., Kansas City
Bart F. Wooldridge, M.D., Joplin

Raymond O. Muether, M.D., St. Louis
John M. Parato, M.D., St. Louis
John P. Frick, M.D., Kansas City
Richard V. Riddell, M.D., St. Joseph
John R. Post, M.D., Washington
William H. Walters, M.D., St. Louis
Edwin H. Rohlfing, M.D., St. Louis
Freeman L. Finley, M.D., St. Louis
Harold H. Cline, M.D., Piedmont
Paul Murphy, M.D., St. Louis
Lyman D. Brown, M.D., Springfield
James R. Compton, M.D., Sarasota, Fla.
Richard W. Anderson, M.D., Kansas City
William W. Buckinham, M.D., Kansas City
William J. Steward, M.D., Columbia
Samuel E. Senor, M.D., St. Joseph
John W. Williams, Jr., M.D., Springfield
Cecil G. Leitch, M.D., Blue Springs
Williard Bartlett, Jr., M.D., St. Louis
Paul C. Wheeler, M.D., Columbia
Aaron J. Reiches, M.D., St. Louis
Ralph D. Stickler, M.D., Kirksville
Charles H. Eyermann, M.D., St. Louis
Irl G. Tremain, M.D., St. Louis
Sidney Rubin, M.D., Kansas City
Helen F. Gibson, M.D., St. Louis
Frank Hurwitt, M.D., Kansas City
E. T. Taylor, M.D., St. Louis
Leo J. Hartnett, M.D., St. Louis
Robert H. Parker, Kansas City

The Speaker invited new business.

Introduction of New Business

The House of Delegates approved the introduction of Resolution #35 by a two-thirds vote. The resolution was introduced by Dr. Harold D. Ridings, Cape Girardeau County Medical Society.

Resolution #35—The American Board of Allergy and Immunology, a Conjoint Board of the American Board of Internal Medicine and American Board of Pediatrics

Resolved, that the Missouri State Medical Association affirms that:

1. The determination of a physician's right to perform a particular function should be made on the basis of his demonstrated competence as judged by his peers;
2. The existence of a specialty board in the field does not preempt the practice of that field of medicine for those certified by that board;
3. The existence of the American Board of Allergy and Immunology, a Conjoint Board of the American Board of Internal Medicine and American Board of Pediatrics, should not prevent otolaryngologists and other specialists, including family physicians, from caring for their patients with allergic conditions and from being paid for doing so. Be it further

Resolved, that the American Board of Allergy and Immunology, a Conjoint Board of the American Board of Internal Medicine and the American Board of Pediatrics, be urged to continue its discussion with the American Board of Otolaryngology, and with other boards which request it, to develop appropriate means of recognition in the field of allergy for diplomats of those boards, and be it further

Resolved, that the American Board of Allergy and Immunology, a Conjoint Board of the American Board of Internal Medicine and the American Board of Pediatrics, be requested to continue its efforts to simplify its title in concert with its sponsoring organizations and in the spirit of improving communications within the profession.

(Referred to the Reference Committee on Medical Education and Public Welfare.)

The House of Delegates approved the introduction of Resolution #36 by a two-thirds vote. The resolution was introduced by Dr. Joseph C. Edwards, St. Louis Medical Society.

Resolution #36—Observation of Emergency Medical Services by Senior Law Students during a 24-Hour Shift with the Senior Surgical Resident and Senior Medical Resident

Whereas, The University of Arkansas Law School has developed over a ten-year period, a seminar including discussion of the methodology and art of medicine, the administrative and medical problems in hospitals and the physicians' responsibilities; directed discussions with physicians in several specialty areas; the mass of paper work required of physicians; why physicians frequently are not eager to state prognosis even though necessary for the lawyer to prove damages, and

Whereas, several law students told their law professor that "afte having been so deeply immersed in the hospital procedures they could no longer comprehend the justification for some of the malpractice cases they had read in the classroom presentations," and

Whereas, better communications between lawyers and physicians should result in better understanding of mutual problems, therefore, be it

Resolved, That the House of Delegates of the MSMA urge the officers of the MSMA to write the Deans of the law schools in the State of Missouri to help the MSMA set up a mechanism whereby such a program for senior law students could be initiated in the State of Missouri, and be it further

Resolved, That the delegates of the MSMA to AMA present the intent of this resolution to the House of Delegates at the AMA for action at the national level throughout the USA.

Adopted by MSMA House of Delegates—April 20, 1975

(Referred to the Reference Committee on Medical Education and Public Welfare.)

The House of Delegates approved the introduction of Resolution #37 by a two-thirds vote. The resolution was introduced by Dr. George A. Ladyman, Butler-Wayne-Ripley-Carter County Medical Society.

Resolution #37—Refusal of Third Party Payments

Whereas, The General American Life Insurance Company of St Louis is a carrier for Part B Medicare; and

Whereas, General American's responsibility is to make payments to physicians for their services or provide an explanation as to why payment is not made; and

Whereas, Blue Cross to St. Louis, a Part A fiscal intermediary pays for hospital charges, at least on occasion, in cases when General American refuses to pay the physician charges; and

Whereas, The submitted cases have come before a Hospital Utilization Review Committee and have been approved for care received; and

Whereas, The refusal from General American has been decided by an "informal review committee"; and

Whereas, Such an "informal review committee" may or may not include a physician and, thereby, provide peer judgment; and

Whereas, When General American refuses payment of claims no explanation of the reason for refusal is provided the physician and

Whereas, Such an explanation would be of educational value to the physician to prevent possible refusals in the future; and

Whereas, The only relief possible for a physician is to take time away from his practice to appear before a hearing; therefore, be it

Resolved, That the MSMA House of Delegates requests General American to identify the makeup of an "informal review committee" and explain the type of review the committee carries out; and be it further

Resolved, That General American provides specific reasons for refusal of physician payments so that the physician may obtain educational value from the refusal.

(Referred to Reference Committee on Resolutions.)

The House of Delegates approved the Resolution #38 by a two-thirds vote. The resolution was introduced by Dr. Ronald A. Youmans, Jackson County Medical Society.

Resolution #38—Public Law 92-603 (PSRO)

Whereas, Title XVIII (P.L. 89-97), (Medicare) as amended by Section 249(f), otherwise known as PL 92-603, (called PSRO) and as implemented by the Secretary of HEW in the regulations of November 29, 1974 (39 FR 41603) violate the letter and the spirit of Section 1801 of the Act, (42 U.S.C. 1395) which states:

"Nothing in this title shall be construed to authorize any Federal Officer or employee to exercise any supervision or control over the practice of medicine, or the manner in which medical services are provided . . . ,"

and

Whereas, Enforcement of PSRO, implementation by the regulations and misinterpretations in intermediary manuals published by the Bureau of Health Insurance legally requires the private medical ractitioner to ration the quantity and to compromise the quality of iedical care, and

WHEREAS, PSRO, the implementing regulations, and the policies ublished in the intermediary manuals of the Bureau of Health Inurance replace and violate the medical judgment of the practicing hysician, invade the privacy of patients, and force the physician to ecome a "claims adjustor" for the Secretary of HEW in accordance ith his norms and criteria such as published in the Federal Reger dated November 29, 1974, Section 405.1035, "regional norms, uch as those developed by abstracting services, or third party payrs . . ." and

WHEREAS, PSRO, the implementing regulations, and the policies ublished in the intermediary manuals of the Bureau of Health Inurance thrust the practicing physician into a clerical and/or fiscal ole which is unrelated to, and which will interfere with, the exercise f his independent medical judgment by subjecting him to the presire of semi-judicial hearings, the outcome of which will determine hether or not the patient, the physician, and the hospital will be renbursed by the Government, and

WHEREAS, An option exists under the provisions of Section 1861 k), (42 U.S.C. 1395x(k)), which states:

"For such review to be made by either (a) a staff committee of ie institution composed of two or more physicians, with or without articipation of other professional personnel, or (b) a group outside ie institution which is similarly composed and (i) which is estabshed by the local medical society and some or all the hospitals and killed nursing facilities in the locality, or (ii) if (and for as long as) iere has not been established such a group which serves such instiition, which is established in such other manner as may be aproved by the Secretary,"

nd is also substantially duplicated by the regulation 20 CFR 05.1035(e)(1) which says:

"(iii) Where a committee(s) or group(s) as described in (i) or ii) above has not been established to carry out all the utilization view functions prescribed by title XVIII, by *a committee(s) or roup(s) composed as in* (i) above, and sponsored and organized i such manner *as approved by the Secretary of Health, Education nd Welfare.*",

Therefore, Be It Resolved, That the implementation (by the Sectary of HEW) of 249(f) P.L. 92-603 (PSRO) as published in the ovember 29, 1974 regulations, be deferred until the legal actions rought against the Secretary of HEW by the AAPS, CMS, and MA, are resolved, and be it further

Resolved, That the Missouri State Medical Association advises l practicing physicians and hospital medical staffs in the state of lissouri of Option III under Section 1861(k)(2) of the Social Seirity Act, and under the regulations 20 CFR 405.1035(e)(1), and e it further

Resolved, That the Missouri State Medical Association insists on ie repeal of PSRO (249(f) P.L. 92-603), and instructs the officers the Missouri State Medical Association to contact each member the United States House of Representatives and each of the nited States Senators from the State of Missouri to request that iey support legislation to repeal Section 249(f) P.L. 92-603 SRO).

(Referred to the Reference Committee on Resolutions.)

There being no further business, the Speaker adjourned ie Second Session of the House of Delegates with the anouncement that the Annual Meeting of the Missouri State ledical Foundation would be held immediately following djournment.

HIRD SESSION
unday, April 20, 1975

The Third Session of the MSMA 117th House of Deleates was called to order by the Speaker, Dr. Robert A. lickman, at 7:30 AM in the Khorassan Room of the Chaseark Plaza Hotel.

Dr. Charles R. Gulick, Chairman, gave the report of the redentials Committee and declared the presence of a quoim. With unanimous consent, the Speaker dispensed with roll call and the reading of the minutes of the two previis meetings.

Dr. Harold B. Rapp, Chairman, was invited to present the port of the Nominating Committee.

NOMINATING COMMITTEE

The Nominating Committee met at 3 PM on April 19, 975 in the Chase-Park Plaza Hotel and has directed me to ibmit the following names on the slate of officers for aproval by the Association:

Vice-President—Dr. Fred D. Fowler, Kansas City
Vice-President—Dr. Lysle M. Bach, Hannibal
Vice-President—Dr. T. Eugene Ruff, Poplar Bluff
AMA Delegate—Dr. Robert A. Slickman, Kansas City
AMA Alternate Delegate—Dr. Hugh E. Stephenson, Jr., Columbia
AMA Delegate—Dr. Hubert A. Ritter, St. Louis
AMA Alternate Delegate—Dr. Lawrence W. O'Neal, St. Louis
Speaker of the House—Dr. James T. Brown, Springfield
Vice-Speaker of the House—Dr. Edwin K. Burford, Jr., Cape Girardeau

(The Speaker invited additional nominations from the floor. Hearing none, he entertained a motion that nominations cease and that a unanimous ballot be cast for the slate as presented by the Nominating Committee. The motion was seconded and carried.)

Dr. John I. Matthews, Secretary, announced that the following Councilors had been elected for two-year terms:

Dr. J. Russell Comer—Second District
Dr. Donald R. Judd—Third District
Dr. Louis P. Hetlage—Fourth District
Dr. William D. Bradshaw—Sixth District
Dr. Howard J. McAlhany—Eighth District
Dr. Eugene T. Hansbrough—Tenth District

At this time, the Speaker invited nominations for the office of President-Elect. Dr. Walter T. Gunn of St. Louis nominated Dr. Max S. Franklin of St. Louis. The nomination was seconded by Dr. George J. Lytton of Kansas City for the Seventh Councilor District and by Dr. Doyle McCraw of Bolivar, a Delegate-at-Large. Dr. John M. Laird, Jr. of Florissant moved that nominations cease and that Dr. Franklin be elected by acclamation.

(The motion was seconded and approved.)

The President-Elect was escorted to the Speaker's stand where he made a brief acceptance statement. Mrs. Franklin also was escorted to the Speaker's stand.

The Speaker then called for additional reports of reference committees.

Dr. Harry S. Jonas, Chairman, was invited to present the additional report of the Reference Committee on Resolutions.

RESOLUTIONS

The meeting of the Reference Committee on Resolutions was held at 6:30 PM in the Khorassan Room on April 18, 1975. Members present were Harry S. Jonas, Chairman, Francis X. Lieb and C. W. Chastain.

The Reference Committee considered two resolutions referred by the House of Delegates which were introduced at the session on April 18.

Resolution #37—Refusal of Third Party Payments

First considered was Resolution #37 introduced by Butler-Wayne-Ripley-Carter County Medical Society.

This resolution concerns itself with identification of "informal review committees" of carriers for Part B Medicare and failure of these committees to explain their decisions.

The Reference Committee recommends adoption of Resolution #37.

(The Speaker called for a vote on Resolution #37. Resolution #37 was adopted.)

Resolution #38—Public Law 92-603 (PSRO)

The Committee next considered Resolution #38, which was introduced by Dr. Ronald A. Youmans.

This resolution addresses itself to certain aspects of Public Law 92-603 (PSRO).

In reviewing this Resolution, several inaccuracies in reference to sections of Public Law 92-603 were noted. Discussion of Resolution #38 was by proponents of the resolution and certain questions were raised which neither they nor members of the Committee were able to answer. The Committee feels that members of the MSMA are entitled to complete and accurate information and discussion of Public Law 92-603. Therefore, the Committee has the following recommendation:

The Reference Committee recommends that Resolution #38 be referred to the Commission on Medical Economics and Third Party Medicine for further study and clarification and that that Commission's report be disseminated to the members of the MSMA.

Mr. Speaker, I move the adoption of this portion of the report.

(The motion to refer Resolution #38 to the Commission on Medical Economics and Third Party Medicine was approved.)

The Speaker invited Dr. Thomas J. Cooper, Chairman, to present the additional report of the Reference Committee on Medical Education and Public Welfare.

MEDICAL EDUCATION AND PUBLIC WELFARE

The Reference Committee on Medical Education and Public Welfare met in the Colonial Room in the Chase-Park Plaza Hotel, St. Louis on April 18, 1975 at 6:15 pm.

Resolution #36—Observation of Emergency Medical Services by Senior Law Students During a 24-Hour Shift with the Senior Surgical Resident and Senior Medical Resident

The Committee recommends approval of Resolution #36, which was introduced by Dr. Joseph C. Edwards of the St. Louis Medical Society.

Mr. Speaker, I move the adoption of this portion of the report.

(The Speaker called for a vote on Resolution #36. Resolution #36 was adopted.)

Resolution #35—The American Board of Allergy and Immunology, a Conjoint Board of the American Board of Internal Medicine and American Board of Pediatrics

The Committee considered Resolution #35. Because of the feeling among some of the members that this might adversely affect their practice of medicine, it is recommended that this resolution not be approved.

Mr. Speaker, I move the adoption of this portion of the report.

(The Speaker then read for the House the Resolves *of Resolution #35, as follows:*

Resolved, That the American Board of Allergy and Immunology, a Conjoint Board of the American Board of Internal Medicine and the American Board of Pediatrics, be urged to continue its discussion with the American Board of Otolaryngology, and with other boards which request it, to develop appropriate means of recognition in the field of allergy for diplomats of those boards, and be it further

Resolved, That the American Board of Allergy and Immunology, a Conjoint Board of the American Board of Internal Medicine and the American Board of Pediatrics, be requested to continue its efforts to simplify its title in concert with its sponsoring organizations and in the spirit of improving communications within the profession.

An extensive discussion followed. Dr. John Laird requested suspension of the rules to allow a non-delegate member of the MSMA to address the House of Delegates on this subject. There were no objections and the rules were suspended.

At this time, Dr. Gene Chapman of Cape Girardeau County Medical Society spoke to the House in favor of Resolution #35. He read a letter which explained the position taken by the Section of the Council on Allergy of the American Medical Association.

Dr. Marvin Singleton of Joplin spoke at length against Resolution #35 and read a resolution which had been approved by the Ear, Nose and Throat Association and which opposed any effort to establish the American Board of Allergy and Immunology without including the American Board of Otolaryngology.

Dr. Wall of Jackson County Medical Society then spoke in favor of Resolution #35.)

Mr. Speaker, when Resolution #35 was discussed, the Reference Committee had been informed that this is a national problem and that it is under consideration by the AMA for their enlightened judgment, which is one of the reasons the Committee recommends disapproval of Resolution #35 at this time

(The Speaker called for a standing vote on Resolution #35. Resolution #35 failed.)

The Speaker invited Dr. Leo Wyrsch, Chairman, to present the report of the Reference Committee on Reports of Officers.

REPORTS OF OFFICERS

The Reference Committee on Reports of Officers met in the Khorassan Room of the Chase-Park Plaza Hotel at 6:15 pm on Friday, April 18, 1975 with all members present.

Resolution #4—Meeting of Component Medical Societies

The Committee reconsidered Resolution #4, which was introduced by Dr. John Laird of the St. Louis Medical Society.

The Committee recommends that the *Resolve* be amended as follows:

Resolved, That the House of Delegates of the Missouri State Medical Association direct the President to appoint an Ad Hoc Committee to study the feasibility of a meeting of the representatives of the component medical societies, and proceed with a meeting if so indicated before the 1976 MSMA session.

Mr. Speaker, the Committee moves for the adoption of Resolution #4 as amended.

(The Speaker explained that this would be an amendment by substitution and called for a vote on the amendment. The amendment carried. He then called for a vote on Resolution #4 as amended. Resolution #4 as amended was adopted.)

The Speaker then asked Dr. James Brown, Vice-Speaker, to assume the Chair.

Unfinished Business

The Vice-Speaker referred to the report of the Reference Committee on Constitution and Bylaws, stating that this report contained a change in *Chapter X. Rules of Order* in the Constitution and Bylaws which was required to lay on the table for a period of one day.

There being no objection to the action, the Vice-Speaker took the amendment from the table without a vote for consideration by the House of Delegates. It reads as follows:

Resolved, That the deliberations of this Association shall be conducted in accordance with parliamentary usages as defined in Sturgis Standard Code of Parliamentary Procedure.

Dr. Robert Slickman, Speaker, moved the adoption of this amendment to the Bylaws.

(The motion was seconded. The Vice-Speaker invited iscussion. There being no discussion, the Vice-Speaker alled for a vote on the adoption of the resolution, stating hat adoption would require a two-thirds vote of the Iouse. The resolution was adopted as an amendment to he Constitution and Bylaws.)

The Speaker resumed the Chair and invited introduction f new business. There was none.

Installation of Officers

The Speaker invited the Officers and Councilors to stand n front of the podium where the Association Secretary, Dr. ohn I. Matthews, administered the oath of office.

The Speaker than invited President R. Allen Chandler to nnounce his commission and committee appointments for 975-1976. Members whose terms had not expired were not nentioned and it is assumed that they will continue to serve.

Committee Appointments

Committee on Constitution and Bylaws—Joseph Conrad, hillicothe; Donald H. Beisner, Springfield (Terms to exire in 1978); Joseph Conrad, Chillicothe, Chairman for the 975-1976 year.

Committee on Legislative Affairs—John I. Matthews, Jeferson City, Chairman; R. Allen Chandler, Kansas City; Max . Franklin, St. Louis; Howard J. McAlhany, Springfield; obert E. Bregant, Jefferson City; Hubert A. Ritter, St. ouis (one-year terms).

Committee on Planning—Francis X. Lieb, St. Louis; Har- y D. Haas, Kansas City (terms to expire in 1980); Paul H. other, St. Charles, Chairman for 1975-1976.

Committee on Voluntary Health Agencies—Carl Siegel, ansas City; Melvin A. Cassel, St. Louis (terms to expire n 1978); William C. Allen, Columbia, Chairman for 1975-976.

Commission on Public Affairs—Sharon Waggoner, St. oseph; R. A. Ritter, Jr., Cape Girardeau; Stanley G. Hall, annibal; A. J. Campbell, Sedalia; Wilber B. Spalding, Jr., ansas City (terms to expire in 1978); Richard P. Bowles, iberty, Chairman for 1975-1976.

Commission Appointments

Commission on Medical Economics, Third Party Medicine nd Governmental Relations—John R. Esther, Joplin; Staney S. Peterson, Springfield; James O. Lottes, St. Louis; . Phillip Acuff, St. Joseph: A. E. Braverman, Kansas City terms to expire in 1978); Max A. Heeb, Sikeston, Chairnan for 1975-1976.

Commission on Continuing Education and Health Manpower—George H. Ladyman, Poplar Bluff; H. Peter Ekern, Mexico; M. Kenton King, St. Louis; Paul R. Young, Columbia; Lucien W. Ide, St. Joseph (terms to expire in 1978); George H. Ladyman, Poplar Bluff, Chairman for 1975-1976.

Commission on Medical-Legal Affairs—George L. Hawkins, Jr., St. Louis; Noel R. Weyerich, St. Louis County; Richard O. Craig, St. Joseph; Harold B. Rapp, Cape Girardeau; William R. McPhee, Kansas City (terms to expire in 1978); Irving H. Clark, Kansas City, Chairman for 1975-1976.

Commission on Interspecialty Medicine—(The name of the Representative will be followed by the name of the Alternate.) *Missouri State Allergy Association,* Jean C. Chapman, Cape Girardeau and Stanley Goldman, Kansas City; *Missouri Society of Anesthesiologists,* Donald J. Dickler, St. Louis and E. E. Bowe, Jefferson City; *Missouri Dermatological Society,* Larry Millikan, Columbia; *Missouri ENT Association,* Forrest H. Kendall, Prairie Village, Kan. and Sam E. Kinney, St. Louis; *Missouri Academy of Family Physicians,* Lois C. Wyatt, Kirkwood and E. David Scott, Jefferson City; *Missouri Society of Internal Medicine,* Robert Bregant, Jefferson City and Clement B. Grebel, St. Louis; *Missouri Society of Neurosurgeons,* August W. Geise, St. Louis and John Kendig, St. Louis; *Missouri OB-GYN Society,* Wallace Stacey, Independence and John P. Ferguson, Jr., Springfield; *Missouri Ophthalmological Society,* Anwar Shah, St. Louis and Philip S. Luedde, St. Louis; *Missouri Orthopedic Association,* Glenn L. McElroy, Columbia and Dale E. Darnell, Kansas City; *Missouri Society of Pathologists,* Henry C. Allen, St. Louis and David Zacharias, Kansas City; *Missouri Chapter, American Academy of Pediatrics,* Don Overend, Springfield and Don Thurston, St. Louis; *Physical Medicine and Rehabilitation,* Franz U. Steinberg, St. Louis and Charles Peterson, Columbia; *Missouri Radiological Society,* Wm. H. McAlister, St. Louis and John J. Lang, St. Louis; *Missouri State Surgical Society,* Cyril Costello, St. Louis and Melvin C. Kasten, Cape Girardeau; *Thoracic Surgical Society,* Charles L. Roper, St. Louis and Richard Yore, St. Louis; *Federation of Missouri Urologists,* Karl J. Kurtz, Kansas City and Milton Ozar, Kansas City; *Chairman of the Committee* for 1975-1976, Cyril Costello, St. Louis.

The Speaker requested an invitation for the meeting place of the next Annual Session of the Association. On behalf of Jackson County Medical Society, Dr. George J. Lytton invited the MSMA to hold the 1976 Annual Session in Kansas City. The invitation was accepted.

The Speaker announced that the 118th Annual Session of the Missouri State Medical Association will be held at the Crown Center Hotel in Kansas City on April 1-4, 1976.

There being no additional business, the Speaker declared the 117th Annual Session adjourned.

Remember These Dates!

118th ANNUAL SESSION

of the Missouri State Medical Association Will Be Held on

APRIL 1-4, 1976

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Bristow, R. B., St. Joseph
Christ, Martin H., St. Joseph
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Dunshee, R. E., Maryville
Fisher, Joseph L., St. Joseph
Fotopoulos, C. K., North Kansas City
Handler, Eric, St. Joseph
Hedges, Richard C., Excelsior Springs
Herman, Allen I., St. Joseph
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Kulowski, Jacob, St. Joseph
McPhee, W. R., Kansas City
Martin, John, St. Joseph
Moen, B. H., St. Joseph
Morgan, Troy, Jr., Albany
O'Connor, William B., St. Joseph
Rosenthal, Irwin I., St. Joseph
Rost, William B., St. Joseph
Schertz, T. B., North Kansas City
Smith, Robert, Brookfield
Sportsman, W. L., Smithville
Stacy, W. T., St. Joseph
Stallard, Donald, St. Joseph
Stevens, Edward M., St. Joseph
Stratman, C. A., Kansas City
Szymanski, S., Macon
Wadlow, Ernest E., St. Joseph

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Bautista, R. L., Moberly
Buhen, Robert W., Hannibal
Burns, Francis R., Hannibal
Campbell, James E., Macon
Cohrs, C. C., Moberly
Comer, J. Russell, New London
Davis, Landis Y., Canton
Fleming, Thomas S., Moberly
Foreman, Phillip B., Hannibal
Hudson, G. R., Moberly
Kruse, Carl R., Palmyra
Lewellen, Charles H., Louisiana
Martin, Joe, Louisiana
Middleton, John W., Louisiana
Miles, Glenn, Louisiana
Plowman, Edward M., Hannibal
Streetor, R. D., St. Louis
Stuerman, Lawrence G., Louisiana
Tarvydas, Francis, Edina

Third Councilor District—268

Abelardo, M. L., St. Louis
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Ahadi, Abd Ul Ahad, St. Louis
Ahern, Arch, St. Louis
Allen, Henry C., St. Louis
Allen, William E., Jr., St. Louis
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Amin, Navin, St. Louis
Anderson, Charles B., St. Louis
Anderson, John M., St. Louis
Anglo, Luis B., St. Louis
Archer, Carol, St. Louis
Auer, Edward T., St. Louis
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Aylward, H. J., St. Louis
Backer, Matt, St. Louis
Banton, Milagros R., St. Louis
Bardsley, John L., St. Louis
Baula, Armindo G., St. Louis
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Binder, Morton A., St. Louis
Bisno, Daniel, St. Louis
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Boldizar, A. G., St. Louis
Bolton, Robert, St. Louis
Bond, Leslie F., St. Louis
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Bowen, S. F., Jr., St. Louis
Bowerman, Harold H., St. Louis
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Brookes, Robert D., St. Louis
Brown, James M., St. Louis
Bruns, Kenneth, St. Louis
Bryan, James H., Clayton
Bryan, William T. K., Brentwood
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Cassel, Melvin A., St. Louis
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Cavanagh, Denis, St. Louis
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Cole, Harry O., St. Louis
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de Ungria, Pablo, St. Louis
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Geisse, Guillermo, St. Louis
Gilden, Jerome J., St. Louis
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Giraparnont, Bang-Orn, St. Louis
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Grindon, J. B., St. Louis
Gulick, Charles R., St. Louis
Gunn, Walter T ., St. Louis
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Hampton, Stanley F., St. Louis
Hardy, David A., Richmond Hts.
Harell, Alex, St. Louis
Hartwig, John A., St. Louis
Hatfalvi, Bela I., St. Louis
Hawker, W. D., St. Louis
Hilbert, Paul H., St. Louis
Hill, XaCadene A., St. Louis
Hofstatter, Leopold, St. Louis
Horenstein, S., St. Louis
Hovadhanakul, Praphat, St. Louis
Hunleth, Frank, St. Louis
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Jones, James H., St. Louis
Judd, Donald, St. Louis
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Kinsella, Peter, St. Louis
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Kuczer, Arnoldo, St. Louis
Kuyakanon, W., St. Louis
Lane, Clinton W., St. Louis
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Larsen, Virginia, St. Louis
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Mowrey, William O., St. Louis
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Mueller, Robert, St. Louis
Murphy, Michael G., St. Louis
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Nahm, C. C., St. Louis
Nash, Helen, St. Louis
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Ohmoto, Masao, St. Louis
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Orenstein, Joseph M., St. Louis
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Pernoud, Michael F., St. Louis
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Philpott, Gordon W., St. Louis
Portuondo, B. C., St. Louis
Potter, Reese H., St. Louis
Powers, W. E., St. Louis
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Saghir, Marcel, St. Louis
Salanga, P. B., St. Louis
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Shah, Naheed, St. Louis
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Simon, Jerome I., St. Louis
Sletten, Ivan, Kirkwood
Smith, Emily L., St. Louis
Spalding, Don, St. Louis
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Steinberg, Franz U., St. Louis
Stergen, N. E., St. Louis
Stokes, James, St. Louis
Stoneman, William, III, St. Louis
Strominger, Donald, St. Louis
Stutsman, A. C., St. Louis
Sullivan, C. J., St. Louis
Tekwani, H. T., St. Louis
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Tichenor, Robert W., St. Louis
Tindall, Robert N., St. Louis
Tjoflat, Oliver E., St. Louis
Trotter, Francis O., Jr., St. Louis
Tucker, George L., St. Louis
Turner, C. M., St. Louis
Ungvari, Joseph C., St. Louis
Virant, John A., St. Louis
Wall, Lester, St. Louis
Walton, Franklin E., St. Louis
Waters, H. R., St. Louis
Webb, Marion A., St. Louis
Wentzel, Louis R., St. Louis
Westerman, Henry C., University City
Westerman, Robert N., St. Louis
Williams, Carol F., St. Louis
Willman, Vallee L., St. Louis
Wochner, R. Dean, St. Louis
Yore, R. W., St. Louis
Younge, Walter A., St. Louis
Zahorsky, T. S., St. Louis
Zwart, Claude H., St. Louis

Fourth Councilor District—113

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Angelo, Thomas L., St. Louis
Ayvazian, Vatche, St. Louis
Baker, Donald L., Union
Balster, Vernon H., St. Louis
Barragan, Hector, Ballwin
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Bolinske, R. E., St. Louis
Bonney, S. C., Washington
Bowles, G. Robert, Kirkwood
Burstein, Robert, Clayton
Callahan, Donald E., Jennings
Canty, E. J., St. Charles
Catanzaro, Rudolph E., St. Louis
Chang, Shih-Chung, St. Louis
Cohen, Robert S., St. Louis
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Damron, E. O., Elsberry
Davidson, Morris, Clayton
Davis, Ed, St. Louis
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Deles, Vicente D., Crystal City

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Diehr, M. A., St. Louis
Donnell, R. H., Crystal City
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Fish, Richard G., St. Louis
Floro, Mariano N., Florissant
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Freiheit, H. J., St. Louis
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Gupta, N. C., St. Louis
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Hallinger, Earl S., Jr., Clayton
Hammes, R. E., St. Charles
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Hetlage, Louis P., Troy
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Keller, R. M., Wentzville
Kendis, Joseph B., St. Louis
King, E. E., Ferguson
Klippel, Allen, St. Louis
Kopp, Jules, St. Louis
Korenblat, Phillip, St. Louis
Kuttner, Marianne, University City
Laird, John, Jr., Florissant
Lauber, Joseph, St. Louis
Lewin, W. Howard, St. Louis
Linsenmeyer, Charles, St. Charles
McKee, Oliver A., Kirkwood
Magness, Guy N., University City
Malt, Sherwin, St. Louis
Mathew, Ruby R., Chesterfield
Mayer, Robert A., Ballwin
Mayfield, James L., Crystal City
Medrano, C. A., St. Louis
Mendelson, David F., St. Louis
Middleton, Jerry N., St. Louis
Minnihan, Robert W., Chesterfield
Mitchell, Thomas J., St. Clair
Monat, Seymour, St. Louis
Montes, A. C., St. Louis
Mueller, Robert S., St. Louis
Nakada, J. R., Clayton
Oglesby, R., St. Louis
Peterson, Frederick D., St. Louis
Phillips, Hanford, St. Louis
Phipatanakul, Supote, Kirkwood
Poggemeier, W., Jr., St. Charles
Rahman, Mohammad, St. Charles
Richardson, George A., Union
Robertson, Frank G., St. Louis
Rother, Paul H., St. Charles
Ruhling, Rudy, St. Louis
Rutledge, John F., Crystal City
Schecter, Samuel E., Clayton
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Schwartz, Melvin, St. Louis
Seabaugh, Ottis D., Lockwood
Shatz, Burton, St. Louis
Simril, W. A., St. Louis
Sisk, James, Clayton
Skilling, David M., Jr., St. Louis
Soucy, John C., St. Charles
Stein, Harry J., St. Louis
Steiner, A. J., Clayton
Stewart, Frances H., St. Louis
Tashma, S., St. Louis
Toon, Thomas J., St. Louis
Torin, Bernice, St. Louis
Ulett, Pearl C., St. Louis
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West, Joseph W., St. Louis
Whitener, Paul R., St. Louis
Wiant, James R., St. Louis
Wilson, David E., Potosi
Wirthlin, E. H., St. Louis
Workman, George, Hermann
Yaeger, Gerald A., St. Charles
Yazdi, A. M., St. Louis

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Allen, William C., Columbia
Almond, Carl H., Columbia
Asel, Norman, Columbia
Black, Samuel P. W., Columbia
Bowe, Edwin E., Jefferson City
Bregant, Robert, Jefferson City
Brubaker, Leonard H., Columbia
Butt, James H., Columbia
Chapel, Jim, Columbia
Cooper, Charles W., Jefferson City
Cope, James C., Columbia
Davis, David, Columbia
Dexter, James D., Columbia
Domke, Herbert, Jefferson City
Durst, Henry, Fulton
Ekern, H. Peter, Mexico
Exon, C. S., Jefferson City
Foote, Jerry, Columbia
Fuchs, George J., Columbia
Garner, Royal, Jefferson City
Gaunt, William, Columbia
Giffen, L. E., Jefferson City
Hall, C. Robert, Versailles
Hart, William M., Columbia
Hubbell, Ira G., Columbia
Ide, Carl H., Columbia
James, Ronald C., Columbia
Jolly, Ben, Mexico
Joseph, Donald J., Columbia
Kanagawa, H. K., Jefferson City
Kauffman, Ruth, Versailles
Kays, Kenneth M., Columbia
Keown, Kenneth, Columbia
Killburn, K. H., Columbia
Lamberti, Joseph, Columbia
Lankford, Harold D., Mexico
Lodwick, Gwilym, Columbia
McCaffree, Mary M., Jefferson City
McCluer, Shirley, Columbia
Marco, Philip, Columbia
Marshall, William G., Glasgow
Matthews, John, Jefferson City
Meinershagen, C. W., Jefferson City
Millikan, L. E., Columbia
Mitchell, Frank L., Columbia
Moranville, B. A., II, Columbia
Nieuwenjuizen, M., Columbia
Oestreich, Alan, Columbia
Overholser, M. D., Columbia
Peterson, Charles R., Columbia
Peterson, Donald B., Fulton
Ross, Gilbert, Jr., Columbia
Schokker, Johannes, Jefferson City
See, William B., Columbia
Shull, G. D., Jefferson City
Siu, Kenneth, Jefferson City
Spratt, J. S., Jr., Columbia
Stephenson, Hugh E., Jr., Columbia
Stewart, W. B., Columbia
Stuart, Byron M., Boonville
Tanner, R. H., Jefferson City
Terry, Boyd E., Columbia
Van Vranken, E. E., Jefferson City
Wallace, Edgar S., Mexico
Walters, John H., Columbia
Walters, Laura, Columbia
Washburn, J. Loren, Versailles
Watts, Byron, Jefferson City
Weiss, James M. A., Columbia
Wilson, George P., Columbia
Winn, George W., Boonville
Young, Paul R., Columbia

Sixth Councilor District—23

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Boydston, Wayne, Odessa
Bradshaw, W. D., Clinton
Campbell, Albert J., Sedalia
Cope, J. S., Lexington
Davault, G. K., Richmond
Eklund, A. W., Pleasant Hill
Jones, Keith D., Warrensburg
Kelling, Jordan, Waverly
King, Richard H., Clinton
Knipschild, B. F., Marshall
LaHue, William C., Lexington
McBurney, C. A., Slater
Magee, Robert L., El Dorado Springs
Maxson, T. Reed, Warrensburg
Pavlu, Robert, Waverly
Pearse, Roy W., Nevada
Raynor, Richard, Marshall
Stockwood, R. C., Sedalia
Torontow, R. J., Nevada
Wetzel, Gus, Clinton
Worley, Charles A., Sweet Sprin
Wray, Rolla B., Nevada

Seventh Councilor District—69

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Bryant, T. J., Kansas City
Buchanan, Barbara, Kansas City
Buhler, Victor B., Kansas City
Calovich, Emery R., Kansas City
Case, William, Kansas City
Chandler, R. Allen, Kansas City
Clark, I. H., Kansas City
Coffey, Ralph R., Kansas City
Crow, Martin L., Kansas City
Curts, Calvin J., Kansas City
Davidson, Ken C., Leawood, Kan.
Dernoncourt, John E., Smithville
Dolan, C. Terrence, Kansas City
Drowns, Bruce V., Kansas City
Engelmann, C. E., Kansas City
Fairchild, Robert C., Kansas City
Flynn, J. M., Kansas City
Fowler, Fred D., Kansas City
Fritzlen, Thomas J., Kansas City
Fuhrman, Donald, Kansas City
Gauthier, Charles P., Kansas City
Goldman, Stanley, Kansas City
Hahn, Fred W., Jr., Kansas City
Hartwig, Frederick H., Shawnee Mission, Kan.
Heilman, Edward J., Kansas City
Hoadley, William, Kansas City
Holman, Joseph G., Kansas City
Hughes, Michael E., Kansas City
Jonas, Harry S., Jr., Kansas City
Kahn, Marvin, Kansas City
Killen, Duncan A., Kansas City
Kranson, Seymour J., Independence
Lee, King Y., Kansas City
Link, Vance E., Independence
Linville, Howard E., Kansas City
Long, Stacy, Kansas City
Lytton, George J., Kansas City
McCallister, Ben, Kansas City
McCanse, Andrew, Kansas City
McKeel, Thomas B., Shawnee Mission, Kan.
MacGee, Edwin, Kansas C ity
Martin, Clyde V., Kansas City
Miller, Gerald L., Kansas City
Noback, Richardson, Kansas City
Ost, Mark D., Kansas City
Ozar, Milton B., Kansas City
Parelman, Allen G., Kansas City
Piepergerdes, Larry G., Kansas City
Pucci, Gregory L., Kansas City
Sauer, Gordon, Kansas City
Schottman, G. W., Kansas City
Slickman, R. A., Kansas City
Smith, Othello, D., Prairie Village, Kan.
Sneid, Phillip, Kansas City
Spalding, Wilber B., Jr., Kansas City
Stacey, Wallace, Independence
Suddarth, Sterling, Kansas City
Tillema, David, Kansas City
Twin, E. J., Kansas City
Wall, Harry C., Kansas City
Waxman, Herbert, Kansas City
Wicks, Edwin O., Kansas City
Wilhelm, Warren F., Kansas City
Williams, George P., Kansas City
Willoughby, James W., Kansas City
Woods, S. Dwight, Kansas City
Youll, Donald, Kansas City
Youmans, R. A., Prairie Village, Kan.

Eighth Councilor District—59

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Ash, Charles J., Springfield
Barnhill, F. R., Springfield
Betz, Richard, Neosho
Blankenship, G. W., Neosho
Bonebrake, M. D., Springfield
Brown, James T., Springfield
Clarke, Michael J., Springfield
Cook, James R., Springfield
Donley, Robert R., Monett
Esparrago, F. R., Jr., Monett
Esther, John R., Joplin
Ferguson, John P., Jr., Springfield
Gaston, Sam L., Joplin
German, Walter A., Jr., Springfield
Glover, Kenneth, Mt. Vernon
Graves, A. J., Mt. Vernon
Griffin, Evelyn, Buffalo
Griffin, O. A., Jr., Buffalo
Hall, David W., Springfield
H'Doubler, F. T., Jr., Springfield
Herfkens, Kenneth, Springfield
Hilton, Paul E., Joplin
Huewe, Douglas A., Springfield
Isaac, Anita M., Springfield
Ivy, H. B., Springfield
Kenney, Roy E., Neosho
Key, James S., Springfield
Kinder, Doyle O., Springfield
Krahn, H. C., Springfield
Lemmon, G. B., Jr., Springfield
Lockhart, C. E., Springfield
Loeb, Richard H., Springfield
McAlhany, Howard, Springfield
McCorkle, E. Lee, Marshall
McCraw, Doyle C., Bolivar
Macdonnell, Thomas, Marshfield
Manalo, Gil B., Carthage
Menchetti, Don, Springfield
Moseley, E. Thomas, Springfield
Penninger, W. H., Springfield
Peterson, Stanley S., Springfield
Scanlon, R. C., Springfield
Schwartz, E. J., Springfield
Shane, Ramon A., Springfield
Silsby, Don J., Springfield
Simpson, Emerson L., Springfield
Singleton, M. A., Joplin
Spalding, D. L., Springfield
Stehr, Christian H., Springfield
Stewart, Robert B., Springfield
Sweeney, Thomas P., Springfield
Tarrasch, Ernest L., Springfield
Walker, William M., Springfield
White, R. Ned, Springfield
Willcoxon, Robert, Joplin
Wilson, Roy E., Springfield
Wooldridge, Wilfred E., Springfield
Wyrsch, Leo M., Springfield

Ninth Councilor District—12

Bass, B. J., Salem
Cooper, Claude, Thayer
Draper, Bernard, Rolla
Feind, E. E., Rolla
Fowler, Marvin L., West Plains
Froelich, Rae W., Lebanon
Hasek, James A., Mountain Grove
Pendell, Paul W., Rolla
Spears, Joe L., Cabool
Stricker, E. A., St. James
Tang, T. C., Salem
Wiles, Jack N., West Plains

Tenth Councilor District—45

Burford, E. K., Jr., Cape Girardeau
Cadwell, Fred, Poplar Bluff
Camp, Richard V., Jr., Poplar Bluff
Carlson, E. C., Poplar Bluff

Chapman, Jean A., Cape Girardeau
Chastain, C. W., Farmington
Cozean, Charles, Cape Girardeau
Datta, N. K., Bonne Terre
Farmer, Norma, Farmington
Fraser, R. A., Poplar Bluff
Gernstetter, S. L., Poplar Bluff
Gifford, Christopher, Shawnee Mission, Kan.
Hansbrough, E. T., Poplar Bluff
Hardy, Stanton L., Desloge
Heeb, Max A., Sikeston
Holcomb, John K., Cape Girardeau
Hoye, Robert C., Farmington
ung, J. Marshall, Cape Girardeau
Kasten, Melvin C., Cape Girardeau
Kinder, Jim, Cape Girardeau
Koldys, Kenneth W., Cape Girardeau
Ladyman, George, Poplar Bluff
Leroux, G. H., Doniphan
McDermott, Alfred, Perryville
McGinty, Charles P., Cape Girardeau
Magaletta, George, Cape Girardeau
Mahboubi, Aziz, Sikeston
Masters, Edwin J., Sikeston
Ramirez, Ricardo M., Poplar Bluff
Rao, A. R., Fredericktown
Rapp, Harold B., Cape Girardeau
Ritter, Raymond A., Jr., Cape Girardeau
Ritter, Raymond A., Sr., Cape Girardeau
Roberts, Perry T., Cape Girardeau
Rodriguez, Gregorio, Charleston
Ruff, T. E., Poplar Bluff
Santos, Romeo I., Kennett
Sargent, John P., Sikeston
Sbell, William, Sikeston
Shoss, Milton, Cape Girardeau
Talbert, C. R., Jr., Cape Girardeau
Till, B. N., Poplar Bluff
Turner, Kirby, Poplar Bluff
Tuttle, Jay F., Farmington
Wilson, David, Potosi

Guest Physicians—74

Ahmad, Maqbool, St. Louis
Alderson, Philip O., St. Louis
Andersen, Howard A., Rochester, Minn.
Arafa, Mostapha, St. Louis
Baer, Robert, Salt Lake City, Utah
Bensinger, Richard, St. Louis
Bhatt, J., St. Louis
Brown, Finley, Jr., Chicago, Ill.
Bryan, Franklin, Ft. Wayne, Ind.
Chai, H., Denver, Colo.
Chang, Ki Rim, St. Louis
Cohen, Jerome D., Clayton
Covarrubias, Jorge A., Kirkwood
Crandbi, S. A., St. Louis
Crane, James P., Lindenwold, N. J.
Croxdale, Michael, Bloomfield, Ind.
Dick, Earl, St. Louis
Dockhorn, Robert, Kansas City
Floyd, Charles, Gulfport, Miss.
Frye, Robert, Rochester, Minn.
Galaktos, Andrew, St. Louis
Gast, Michael, St. Louis
Gerhardt, Donald, Manchester
Gideon, Charles, St. Louis
Goodrich, Howard B., Orlando, Fla.
Gotway, C. A., Springfield, Ill.
Goldstein, Bernard, St. Louis
Hebert, Gaston A., Hot Springs, Ark.
Henry, Patrick, Columbia
Hermann, Robert E., Cleveland, Ohio
Hobson, Francis, St. Louis
Jirka, Frank J., Jr., River Forest, Ill.
Kaufman, J. R., Ft. Wayne, Ind.
Kolomijcen, Alex, Darien, Ill.
Kuoerflev, Peter T., Bellevue, Wash.
Lefrak, Stephen, St. Louis
Leslie, Stephen, Kansas City
McFarlane, Peter J., Alton, Ill.
McHenry, Martin C., Cleveland, Ohio
McNeill, L. E., Toledo, Ill.
McWhitley, Douglas, Overland Park, Kan.
Majmundar, Kiran A., St. Louis
Mehta, D., Shrewsbury
Mendelsohn, George E., St. Louis
Muhlendorf, Kenneth, St. Louis
Mujumdar, S. S., Brentwood
O'Connor, Timothy, St. Louis
Parker, Lee, Fayetteville, Ark.
Phipatanakul, C., St. Louis
Rodrigo, Tarlila, Columbia
Rubin, Donald M., New York, N. Y.
Rush, Charles A., Fort Worth, Tex.
Rusk, Howard, New York, N. Y.
Sahshen, Melvin, Washington, D. C.
Samter, Max, Evanston, Illinois
Secker-Walker, Roger M., Creve Coeur
Senior, Robert, St. Louis
Shah, Yogendra, A., Brentwood
Shaner, Thomas, St. Louis
Shepard, Dennis, Santa Maria, Calif.
Simons, Milton, Omaha, Neb.
Solomon, William, Ann Arbor, Mich.
Stempel, L. E., St. Louis
Stoddard, Elizabeth, St. Louis
Straub, Oscar, St. Louis
Stricker, Charles X., St. Louis
Sunwoo, In Sook, St. Louis
Umbright, Alan, Maryland Heights
Valdez, Romulo, Rudolph, Vt.
Welt, Selman, St. Louis
White, Leonard, Columbia
Whittier, Frederick, Overland Park, Kan.
Wilhelm, Tozia, Shawnee Mission, Kan.
Wyman, Herbert J., Leawood,
Wyman, Herbert J., Leawood, Kan.

There were 765 members, 74 guest physicians, 159 exhibitors, 175 Woman's Auxiliary members, 56 guests registered and 20 staff members. Total registration was 1,175.

117TH ANNUAL SESSION EXHIBITORS

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Ciba Pharmaceutical Company, Kansas City
Clinical Laboratories of St. Louis, Inc., Creve Coeur
Coca-Cola USA, Chicago, Ill.
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Homemakers Upjohn, St. Louis
The Key Company, St. Louis
Mallinckrodt, Inc., Hazelwood
Marion Laboratories, Inc., Kansas City
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Medical Facilities, Inc., St. Louis
The Medical Protective Company, Fort Wayne, Ind.
Meyer Laboratories, Inc., Fort Lauderdale, Fla.
Missouri Seven-Up Bottlers, St. Louis
Missouri State Medical Association, Jefferson City
Munns Medical Supply Company, Inc., Topeka, Kan.
Office Machines, Inc., St. Louis
Organon, Inc., West Orange, N. J.
Pfizer Laboratories, Inc., Chicago, Ill.
Professional Research, Inc., Los Angeles, Calif.
Ree X-ray, Shawnee, Kan.
Rowell Laboratories, Inc., Baudette, Minn.
Sandoz Pharmaceuticals, East Hanover, N. J.
Searle Laboratories, Chicago, Ill.
Seiler Instrument & Manufacturing Co., Inc., St. Louis
Social Security Disability Insurance, Kansas City
Southern Medical Association, Birmingham, Ala.
Stuart Pharmaceuticals, Wilmington, Del.
Tab Products Company, St. Louis
United Medical Equipment Company, Kansas City
The Upjohn Company, Kalamazoo, Mich.
Vita Mix Corporation, Cleveland, Ohio
Wampole Laboratories, Stamford, Conn.

In lieu of Exhibits, the following firms made cash donations to assist in the sponsorship of Scientific Sessions:

Geigy Pharmaceuticals, Ardsley, New York
Eli Lilly and Company, Indianapolis, Indiana
E. R. Squibb & Sons, Inc., Princeton, N. J.

Missouri State Medical Foundation

Minutes of the Annual Meeting
Chase-Park Plaza Hotel, St. Louis
April 18, 1975

In the absence of Albert D. Cross, M.D., President, the meeting was called to order by Charles R. Doyle, M.D., Secretary-Treasurer.

The minutes of the 1974 Annual Meeting in Kansas City, which immediately followed the Friday afternoon April 18 Session of the MSMA House of Delegates, had been published in the July 1, 1974 issue of Missouri Medicine. The minutes were approved as published.

Dr. Doyle directed attention to the financial statement of the Foundation, as of Dec. 31, 1974, which reads as follows:

FINANCIAL STATEMENT FOR THE YEAR 1974

LENNERSTON & COMPANY

Certified Public Accountants

ST. LOUIS, MISSOURI 63144

January 29, 1975

Missouri State Medical Foundation
113 Madison
Jefferson City, Missouri 65101

Gentlemen:

An examination was made of the Balance Sheet of the Missouri State Medical Foundation, a non-profit Missouri corporation, for the year 1974. The Balance Sheet at December 31, 1974 is on the cash basis and the additions and deductions for the year are set forth in Exhibit A.

Recorded receipts for the year were traced in total into the bank account as deposits and paid checks were seen for the disbursements. A direct confirmation was received from the depository in verification of the cash balances on deposit.

A summary of the loans to medical students follows:

Loans Receivable January 1, 1974	$477,672.66
Loans made during the year	79,000.00
Total	$556,672.66
Less Loan Repayments	34,092.83
Loans Receivable December 31, 1974	$522,579.83

Positive confirmations were mailed on 335 individual loans stating their principal loan balances as of September 25, 1974. As of January 14, 1975, 320 confirmations have been returned confirming their principal loan balances at September 25, 1974 of $504,138.73 out of total loans of $522,579.83. Interest income on loans is recorded on a cash basis and the amount received in 1974 was $11,648.47. Accrued interest on outstanding loans at December 31, 1974 amounted to $36,029.40 and is not included in the loan balances in Exhibit A.

The Foundation has set up a reserve for losses on student loans in the amount of .05% monthly on the outstanding loan balances. An addition of $3,091.81 was made for the year 1974 resulting in a reserve balance of $5,846.57 at December 31, 1974.

Interest received on the savings account and the certificates of deposit amounted to $3,962.93 of which $1,838.33 were earned on certificates of deposit in 1973. The certificates of deposit were redeemed on the due dates and the money was deposited to the savings and checking account.

The Missouri State Medical Foundation incurred the following expenses for the year ended December 31, 1974:

State Registration Fee	$ 1.00
Professional Fees	1,445.00
Office Expense	16.45
Printing	76.75
Administrative Service	6,600.00
Addition to Reserve for Losses	3,091.81
Total	$11,231.01

U. S. Treasury Department form 990 and Schedule A will be prepared for the year 1974 and are due for filing by May 15, 1975. The Foundation is not liable for Federal Income Taxes as it is classified as a Tax Exempt Charitable Organizaiton.

We have examined the Balance Sheet of Missouri State Medical Foundation as of December 31, 1974, prepared on the cash basis. The examination was made in accordance with generally accepting auditing standards and include such tests of the accounting records and such other auditing procedures as we considered necessary in the circumstances. Since the Balance Sheet is on the cash basis, no opinion is expressed on the attached statement as accrued interest on loans of $36,029.40 is not shown.

Yours very truly,
Lennerston & Co.
Certified Public Accountants

Missouri State Medical Foundation
Balance Sheet (Cash Basis), December 31, 1974

Assets

Cash		
Checking Account	$ 44,936.24	
Savings Account #05842586	47,086.21	
Total Cash		$ 92,022.45
Loans Receivable from Medical Students	$522,579.83	
Less Reserve for Losses	5,846.57	516,733.26
		$608,755.71

Fund Reserve

Balance January 1, 1974		$561,548.32
Additions for the Year 1974		
Interest on Student Loans	$ 11,648.47	
Interest on Bank Deposits	3,962.93	
Contributions (detailed below)	2,777.00	
Assessment of Members, Active $10.00	40,050.00	58,438.40
		$619,986.72
Less Expenses for the Year 1974		
Administrative Services	$ 6,600.00	
Professional Fees	1,445.00	
Printing, Meeting and Misc. Expense	94.20	
Provision for Losses on Student Loans	3,091.81	11,231.01
		$608,755.71

Contributions

Cole County Medical Auxiliary	$ 367.00
Woman's Auxiliary to MSMA	300.00
Woman's Auxiliary to Jackson County	100.00
Grand River Medical Society	200.00
West Central Missouri Medical Society	250.00
Max S. Franklin, M.D.	100.00
Albert D. Cross, M.D.	100.00
Greene County Medical Auxiliary	100.00
Doyle C. McCraw, M.D.	100.00
Clay County Medical Auxiliary	830.00
Sub Total	$2,447.00
Contributions under $100 each	330.00
Total Contributions	$2,777.00

Dr. Robert H. Tanner, a member of the Board of Trustees, expressed appreciation for the generous support and contributions of the MSMA Woman's Auxiliary and the various individual county medical society auxiliaries.

There was an extensive discussion of possible ways in which to establish better communications with each county auxiliary and to further recognize their efforts on behalf of the MSMF.

Mr. Ron Ellison, Assistant Secretary, reported that additional contributions have been received from county auxiliaries since Dec. 31, 1974 and he wished to update this section of the 1974 financial statement as follows:

Boonville Medical Group	$100.00
Max S. Franklin, M.D.	100.00
Woman's Auxiliary to MSMA	300.00
Miller's Medical Arts Pharmacy, Inc.	100.00
Buchanan County Medical Auxiliary	110.00
	$710.00
Contributions under $100.00	270.00
Total Contributions	$980.00

Mr. Ellison noted that he had had the opportunity to make a personal presentation to one county medical auxiliary which resulted in greater enthusiasm and understanding of the MSMF and what the funds are accomplishing.

There was a discussion of the advantages and disadvantages of contacting MSMA members for contributions via direct mail or promotion in Missouri Medicine.

Dr. Doyle C. McCraw pointed out the importance of members making contributions to the MSMF in memory of eceased family members and friends. He pointed out that ore funds are needed in view of Missouri's fourth medical hool in Kansas City and the current trend of inflation.

Dr. Max S. Franklin discussed briefly the current assess- ent of members for the MSMF.

There was a discussion of additional possibilities of fund- g the MSMF.

Max S. Franklin, M.D., St. Louis was reelected to the oard of Trustees by a unanimous vote to serve a five-year rm.

R. Allen Chandler, M.D., Kansas City, incoming President of the MSMA, was unanimously elected as an Ex Officio Member of the Board to replace James C. Cope, M.D., retiring MSMA President.

The President called for the introduction of new business. There being no new business, he announced that a short meeting of the MSMF Board of Trustees would immediately follow the Annual Meeting of the Missouri State Medical Foundation.

The meeting was adjourned.

inutes of the MSMF oard of Trustees Meeting hase-Park Plaza Hotel, St. Louis pril 18, 1975

In the absence of Albert D. Cross, M.D., President, the eeting of the Board of Trustees of the Missouri State Med- al Foundation was called to order by Charles R. Doyle, .D., Secretary-Treasurer.

The first order of business was the election of officers. On ehalf of the Nominating Committee, Dr. Doyle C. Mc- raw, Chairman, nominated the following slate of officers r reelection for one-year terms:

President—Albert D. Cross, M.D., Trenton
Vice-President—Kenneth C. Hollweg, M.D., Kansas City
Secretary-Treasurer—Charles R. Doyle, M.D., St. Louis

The President called for nominations from the floor. There ere none.

It was moved and seconded that the above officers be re- ected by acclamation.

Mr. Ron Ellison, Jefferson City, was appointed Assistant Secretary to assist in the administration of the Foundation's program.

As reported in the agenda for the meeting, the expenses paid by the Foundation in 1974 totaled $8,139.20 which includes $6,600.00 for office salaries and $1,539.20 for professional fees, stationery and other related expenses.

There was a lively discussion of the current loan interest schedule and the criteria by which loans are awarded to Missouri student applicants. However, no changes or decisions were made. Dr. Doyle's recommendation that the Board of Trustees study both subjects and present further information and proposals at the 1975 meeting of the Board in Kansas City.

There being no further business, the meeting was adjourned.

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The Council Reports

Members of April 20, 1975

R. Allen Chandler, M.D., Kansas City, President, called the meeting to order. Those present were Drs. Chandler; Max S. Franklin, St. Louis; John I. Matthews, Jefferson City; Richard V. Bradley, St. Louis; James C. Cope, Columbia; Robert A. Slickman, Kansas City; James T. Brown, Springfield; Howard J. McAlhany, Springfield; John N. Martin, St. Joseph; J. Russell Comer, Hannibal; Donald R. Judd, St. Louis; Louis P. Hetlage, Troy; Robert E. Bregant, Jefferson City; Andrew McCanse, Kansas City; Claude W. Cooper, Thayer; Eugene T. Hansbrough, Poplar Bluff; Rae W. Froelich, Lebanon; Stanley S. Peterson, Springfield; Frederick D. Peterson, St. Louis; William C. Allen, Columbia; Messrs. Allen D. Smith, Kansas City; Hollister S. Smith, St. Louis; Roger Weis, Kansas City; Ray McIntyre, Royal O. Cooper, Cork Swarnes, Ron Ellison, Staff.

ELECTION OF OFFICERS

President Chandler opened the meeting and introduced the following new Councilors: Drs. Donald R. Judd, St. Louis, 3rd District, and J. Russell Comer, Hannibal, 2nd District. He also extended congratulations to those Councilors who were reelected—Dr. Louis P. Hetlage, 4th District; Dr. William D. Bradshaw, 6th District; Dr. Howard J. McAlhany, 8th District and Dr. Eugene T. Hansbrough 10th District.

Dr. Hetlage introduced Dr. Frederick D. Peterson, St Louis, the new Vice-Councilor for the 4th District.

Dr. Howard J. McAlhany was elected Chairman of the Council and, thereby, became the presiding officer.

Dr. John Martin was elected Vice-Chairman of the Council, Dr. John I. Matthews was elected Secretary and Dr. Richard Bradley was elected Treasurer.

AMA BOARD OF TRUSTEES

Dr. Froelich stated that the AMA Delegates had two resolutions for the AMA House on which they would like Council approval. The first resolution reads as follows:

> *Resolved,* That the House of Delegates of the American Medical Association instruct the Board of Trustees to direct its major or an equal thrust of activity toward legislative, economic and field service activity; and be it further
>
> *Resolved,* That any further economies be made in the area of transference of fiscal monetary responsibility for publications to the respective publication specialty group with the elimination of PRISM and other non-vital publications.

MSMA Councilors await the opening of the organizational meeting in St. Louis on April 20. *(Left to right)* Dr. Donald R. Judd, St. Louis, newly elected Councilor for the Third District; Dr. Louis P. Hetlage, Troy, reelected for the Fourth District; Dr. J. Russell Comer, Hannibal, newly elected for the Second District; and Dr. Howard J. McAlhany, Springfield, reelected for the Eighth District.

Dr. Froelich indicated that the AMA's financial problems ere under study by a Committee and that this committee to report back to the House of Delegates at its Annual leeting. Missouri's AMA Delegates would like to have the bove stated resolution available if the committee does not ome up with satisfactory measures in regard to AMA finanial problems.

A discussion was held in regard to whether the direct ref- rence to PRISM should be left in the resolution. Motion as made, seconded and carried that the above stated reso- ition be accepted as given.

Dr. Froelich also introduced the following resolution:

> *Resolved,* That the recent action of the AMA Board of Trustees interposing legal action between the Department of Health, Edu- tion and Welfare's regulation requiring utilization review of hos- tal admission of our patients is commended; and be it further
> *Resolved,* That the AMA Board of Trustees be encouraged to ontinue to take definitive action between any further legislation or gulation which interferes with the ability of our patients to obtain ur services.

Motion was made, seconded and adopted that this resolu- on be accepted as written.

FINANCE COMMITTEE

Dr. McAlhany made the following appointments to the inance and Budget Committee for 1975-1976: Drs. Brad- y, Chairman; Chandler, Franklin, Martin, Hetlage and IcAlhany.

VICE-COUNCILOR

Dr. Hetlage indicated that the Committee on Constitution nd Bylaws had suggested that if a Councilor could not at- nd a Council meeting, he could appoint a designee to at- nd the Council meeting in his place. He asked whether or ot this Vice-Councilor could attend all Council meetings nd if this Vice-Councilor could vote in the absence of the ouncilor.

Dr. McAlhany reported that the Vice-Councilor is wel- ome to attend all Council meetings.

Dr. Cope stated that he felt that official recognition hould be given to Mrs. Martha McIntyre, Mrs. Karen Swar- ns, Mrs. Carol Ellison and Mrs. JoAnn Wilson for their ork and participation in the Annual Session.

Motion was made, seconded and carried that the official anks of this organization be extended to these ladies.

BOARD OF HEALING ARTS

Dr. Martin, a member of the State Board of Registration r the Healing Arts, reported that problems had recently arisen as to who could hire and fire the Executive Secretary of the Board and who had control of the investigators for the Board. He reported that the Board felt that they, not the Director of the Department of Consumer Affairs, Regulation and Licensing, had the right to choose their Executive Secretary and the right to control the activities of the investigators.

Dr. Howard J. McAlhany *(left)*, Eighth District Councilor was elected Chairman of the MSMA Council and Dr. John N. Martin, First District Councilor, was elected Vice-Chairman.

Dr. Martin asked that if the Board should file suit in this matter, could the Board expect any support from the Missouri State Medical Association.

Motion was made, seconded and carried that in the event the Board of Registration for the Healing Arts files suit in this situation, the Board would have the support of the Missouri State Medical Association.

NEXT COUNCIL MEETING

The next meeting of the Council will be held on Friday night, May 30, and Saturday, May 31 at the Ramada Inn in Jefferson City. Chairman McAlhany indicated that the same format will be followed as in the past.

The meeting was adjourned.

Mr. Mark C. Kasten *(left)* from the University of Mis- ouri-Kansas City School of Medicine, was the first Student elegate to serve in the MSMA House with his father, Dr. elvin C. Kasten, a Delegate from Cape Girardeau County edical Society.

MSMA President-Elect Max S. Franklin *(left)* and President R. Allen Chandler attended the April 20 meeting of the Council and discussed subjects of importance to the MSMA in 1975-1976.

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ution patients against hazardous occupa-
ns requiring complete mental alertness
g., operating machinery, driving). Though
ysical and psychological dependence have
rely been reported on recommended doses,
e caution in administering to addiction-
one individuals or those who might increase
sage; withdrawal symptoms (including
nvulsions), following discontinuation of the
ug and similar to those seen with barbitu-
tes, have been reported. Use of any drug in
egnancy, lactation, or in women of child-
aring age requires that its potential benefits
weighed against its possible hazards.
Precautions:
ORAL: In the elderly and debilitated and in
ildren over six, limit to smallest effective
sage (initially 10 mg or less per day) to
eclude ataxia or oversedation, increasing
adually as needed and tolerated. Not recom-
ended in children under six.
INJECTABLE: Keep patients under observa-
n, preferably in bed, up to three hours after
itial injection; forbid ambulatory patients to
erate vehicle following injection; do not
minister to patients in shock or comatose
ates; use reduced dosage (usually 25 to 50
g) for the elderly or debilitated and for
ildren age twelve or older.
ORAL AND INJECTABLE: Though generally
t recommended, if combination therapy
th other psychotropics seems indicated,
refully consider individual pharmacologic
fects, particularly in use of potentiating
mpounds such as MAO inhibitors and
enothiazines. Observe usual precautions in
esence of impaired renal or hepatic func-
n. Paradoxical reactions (e.g., excitement,
imulation and acute rage) have been
ported in psychiatric patients and hyper-
tive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

LIBRIUM 5 ROCHE
LIBRIUM 25 ROCHE
LIBRIUM 10 ROCHE

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

With the injectable form, isolated instances of hypotension, tachycardia and blurred vision have been reported; also hypotension associated with spinal anesthesia, and pain following I.M. injection.

Usual Daily Dosage: Individualize for maximum beneficial effects. *Oral: Adults:* Mild and moderate anxiety and tension, 5 or 10 mg *t.i.d.* or *q.i.d.*; severe states, 20 or 25 mg *t.i.d.* or *q.i.d. Geriatric patients:* 5 mg *b.i.d.* to *q.i.d.* (See Precautions.)

For Parenteral Administration: Should be individualized according to diagnosis and response. While 300 mg may be given during a 6-hour period, do not exceed this dose in any 24-hour period. To control acute conditions rapidly, the usual initial adult dose is 50 to 100 mg I.M. or I.V. Subsequent treatment, if necessary, may be given orally. (See Precautions.)

Supplied:
Oral: Librium® (chlordiazepoxide HCl) *Capsules*—5 mg, 10 mg, 25 mg—bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 50, available singly and in trays of 10.

Libritabs® (chlordiazepoxide) *Tablets*—5 mg, 10 mg and 25 mg—bottles of 100 and 500.

Injectable: Librium® (chlordiazepoxide HCl) *Ampuls*—Duplex package consisting of a 5-ml dry-filled ampul containing 100 mg chlordiazepoxide HCl in dry crystalline form, and a 2-ml ampul of Special Intramuscular Diluent (for I.M. administration). Before preparing solution for I.M. or I.V. administration, please consult package insert for instructions on preparation and administration of solutions. Boxes of 10.

ROCHE
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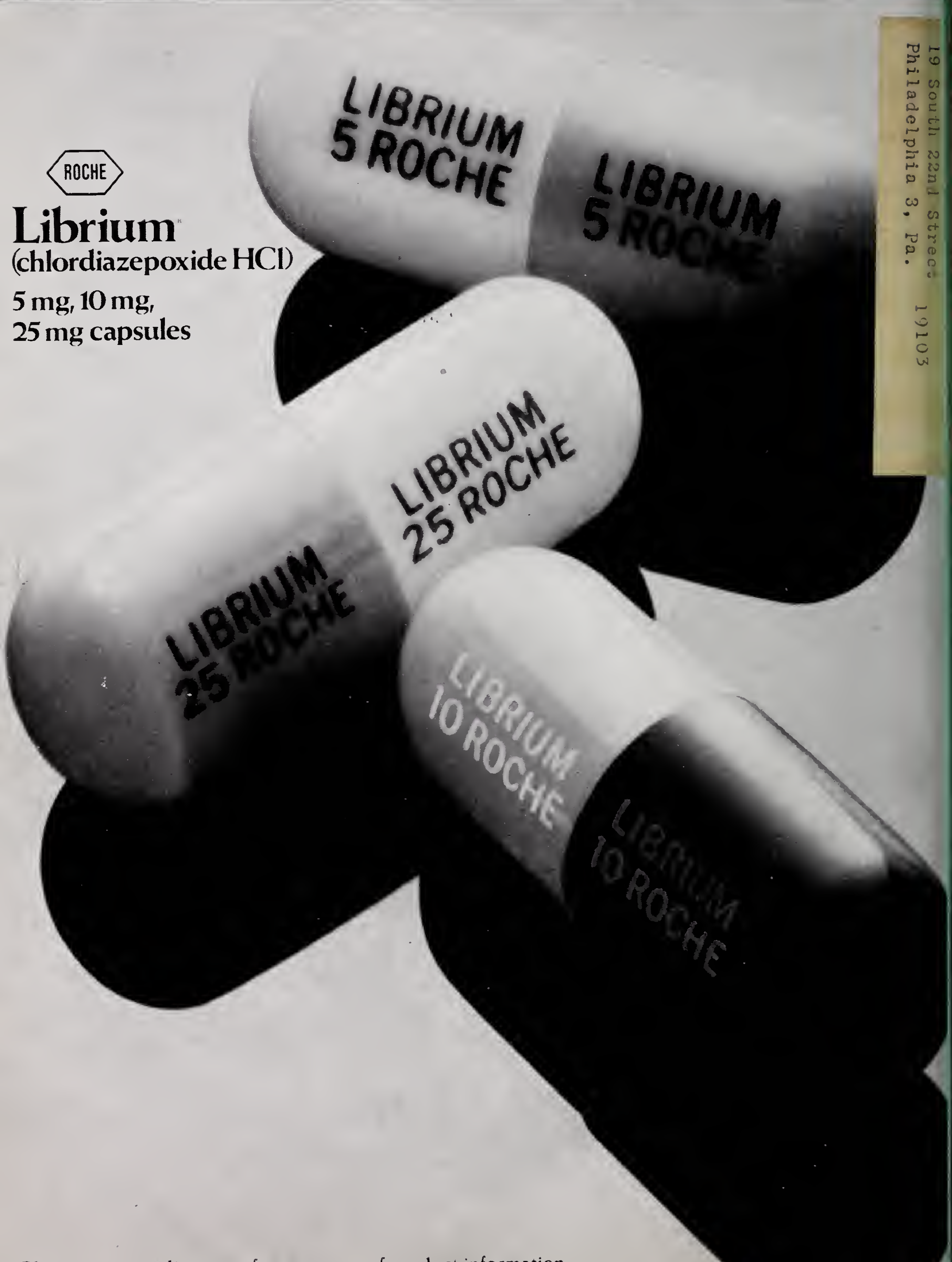
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

Librium®
(chlordiazepoxide HCl)
5 mg, 10 mg, 25 mg capsules

lease see following page.

Disruptive anxiety usually meets its match here


LIBRIUM
5 ROCHE
LIBRIUM
5 ROCHE
LIBRIUM
25 ROCHE
LIBRIUM
25 ROCHE
LIBRIUM
10 ROCHE
LIBRIUM
10 ROCHE

ROCHE

Librium
(chlordiazepoxide HCl)
5 mg, 10 mg,
25 mg capsules

Please see preceding page for summary of product information.

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Missouri Medicine

JOURNAL OF THE MISSOURI STATE MEDICAL ASSOCIATION

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VOLUME 72, NUMBER 7-X

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118th MSMA Annual Session
April 1-4, 1976, Kansas City

Missouri Medicine

THE JOURNAL OF THE MISSOURI STATE MEDICAL ASSOCIATION

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Lawrence W. O'Neal, M.D., St. Louis, *Alternate*
Robert A. Slickman, M.D., *Kansas City*

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Joseph V. Finnegan
Editor

Purposes of Association

THE PURPOSES of the Missouri State Medical Association are to bring into compact organization the entire medical profession of the State of Missouri with the view of the extension of medical knowledge and the advancement of medical science, to promote and elevate the standards of medical education and the enactment and enforcement of just medical and public health laws, to encourage friendly intercourse among physicians, to guard and sustain measures of interest and advantage to the public and the medical profession and to promote science, knowledge and skill among the medical profession.

1950 MSMA Handbook
Centennial Issue

How to Use This Directory

This Directory includes two rosters of physicians who are members of the Missouri State Medical Association.

The **Roster of Members by County Societies** on page 429 lists each county medical society in alphabetical order, the members of each county medical society and their street addresses.

If you are seeking a street address and do not know to which county medical society a member belongs, turn to the **Alphabetical Roster of Members** on page 411 which lists that member's name and the community in which he lives.

Locate the name of that community in the **Guide to County Medical Societies** on page 409 which tells you the county in which that community is located and the county medical society to which that member normally would belong.

The **Roster for the Woman's Auxiliary to the MSMA**, beginning on page 458, lists the officers, directors, committee chairmen, MSMA Advisory Council, presidents of county auxiliaries, districts, state past-presidents and members of each county auxiliary.

For other departments, please refer to the table of contents on the cover page.

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Immediate Past-President

Lysle M. Bach
Vice-President

T. Eugene Ruff
Vice-President

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Missouri State Medical Association

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Secretary

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Vice-Speaker

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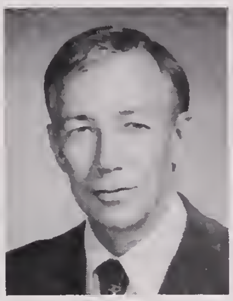
Stanley S. Peterson
(1975-1976)

Hector W. Benoit, Jr.
(1974-1975)


Rae W. Froelich
(1975-1976)

Robert A. Slickman
(1976-1977)

Hubert A. Ritter
(1974-1975, 1976-1977)

Alternate Delegates

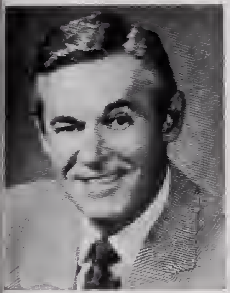
James C. Sisk
(1975-1976)

Melvin C. Kasten
(1975-1976)

Hugh E. Stephenson, Jr.
(1974-1975, 1976-1977)

Lawrence W. O'Neal
(1974-1975, 1976-1977)

The Council

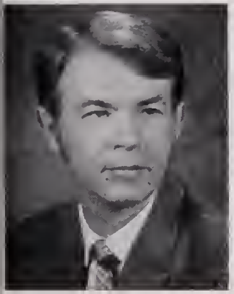

John N. Martin
1st District
Vice-Chairman

J. Russell Comer
2nd District

Donald R. Judd
3rd District

Louis P. Hetlage
4th District

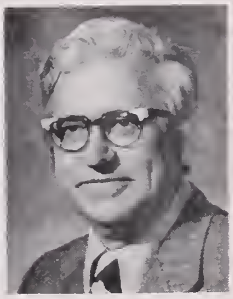
Robert E. Bregant
5th District


William D. Bradshaw
6th District

Andrew McCanse
7th District

Howard J. McAlhany
8th District
Chairman

Claude W. Cooper
9th District


Eugene T. Hansbrough
10th District

MSMA Committees and Commissions 1975-1976

STANDING COMMITTEES

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Publication Committee—Joseph V. Finnegan, St. Louis, Chairman; William C. Mixson, Kansas City; Charles S. Sherwin, St. Louis; Bryon M. Stuart, Boonville; Wilfred E. Wooldridge, Springfield (1976).

Legislative Affairs—John I. Matthews, Jefferson City, Chairman; R. Allen Chandler, Kansas City; Robert E. Bregant, Jefferson City; Max S. Franklin, St. Louis; Hubert A. Ritter, St. Louis; Howard J. McAlhany, Springfield (1976).

Planning—Paul H. Rother, St. Charles, Chairman (1978); Oral B. Crawford, Springfield (1976); James A. Hasek, Mountain Grove (1976); William D. Bradshaw, Clinton (1977); J. Will Fleming, Moberly (1977); T. N. Cofer, Chillicothe (1978); Charles McGinty, Cape Girardeau (1979); James C. Cope, Columbia (1979); Francis X. Lieb, St. Louis (1980); Harry D. Haas, Kansas City (1980).

Voluntary Health Agencies—William C. Allen, Columbia, Chairman (1977); Joseph L. Fisher, St. Joseph (1976); Paul S. Quinn, Springfield (1976); Carl Siegel, Kansas City (1978); Melvin A. Cassel, St. Louis (1978).

STANDING COMMISSIONS

Public Affairs—Richard P. Bowles, Liberty, Chairman (1976); Byron E. Watts, Jefferson City (1976); Hubert A. Ritter, St. Louis (1976); James C. Denninghoff, Columbia (1976); Richard A. Sutter, St. Louis (1976); Francis M. Corry, Springfield (1977); Donald R. Germann, Kansas City (1977); James D. Grable, Portageville (1977); Joseph Kendis, St. Louis (1977); Allen P. Klippel, St. Louis (1977); R. A. Ritter, Jr., Cape Girardeau (1978); Stanley G. Hall, Hannibal (1978); A. J. Campbell, Sedalia (1978); Sharon Waggoner, St. Joseph (1978); Wilber B. Spalding, Jr., Kansas City (1978).

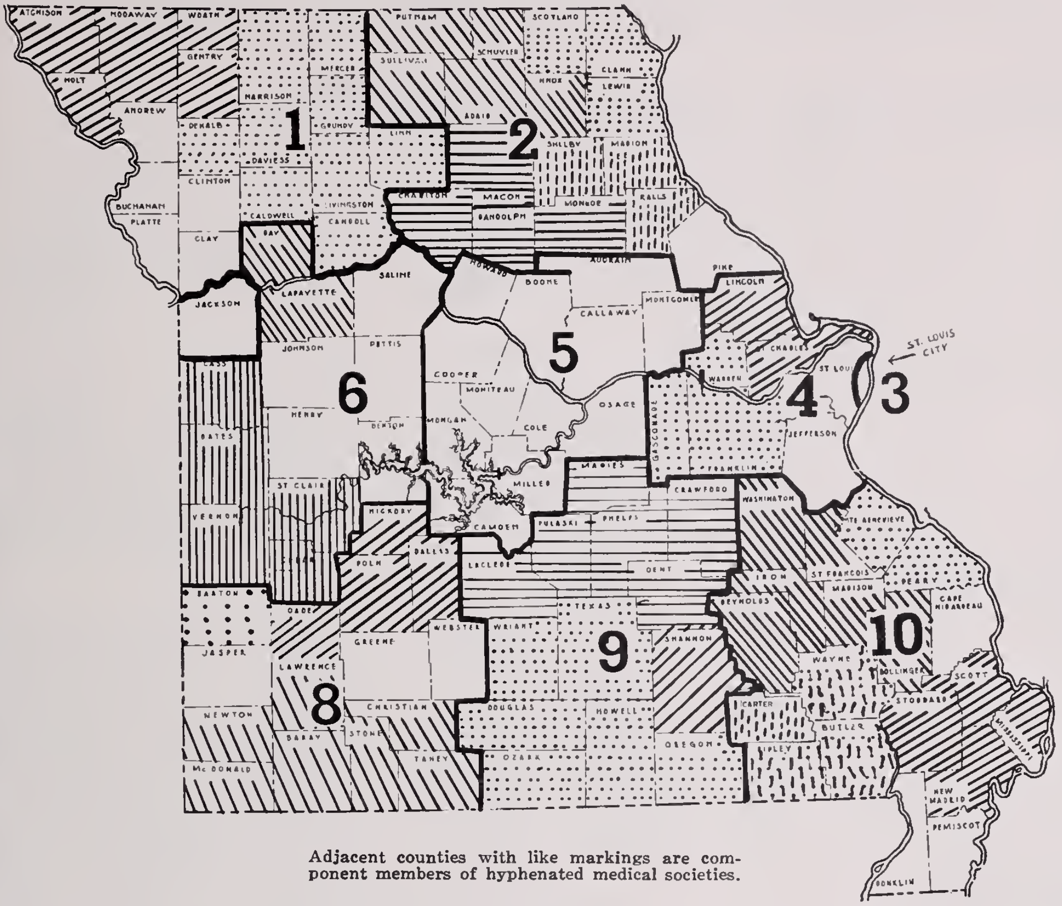
Medical Economics, Third Party Medicine and Governmental Relations—Charles W. Chastain, Farmington, Chairman (1977); Herbert C. Wiegand, St. Louis (1976); Max A. Heeb, Sikeston (1976); Kenneth K. Keown, Columbia (1976); E. J. Cunningham, Jr., Ballwin (1976); Rae W. Froelich, Lebanon (1976); John Torontow, Nevada (1977); E. Warren Allen, Carrollton (1977); John M. Laird, Florissant (1977); John A. Griffith, Jr., Kansas City (1977); Stanley S. Peterson, Springfield (1978); John R. Esther, Joplin (1978); James O. Lottes, St. Louis (1978); R. Phillip Acuff, St. Joseph (1978); A. E. Braverman, Kansas City (1978).

Continuing Education and Health Manpower—George H. Ladyman, Poplar Bluff, Chairman (1978); Andrew McCanse, Kansas City (1976); A. Sherwood Baker, Columbia (1976); Richard J. Dames, St. Louis (1976); John C. Soucy, St. Charles (1976); Charles A. Worley, Sweet Springs (1976); Robert Dettmer, Ironton (1977); Robert B. Deitchman, St. Louis (1977); Marvin A. Singleton, Joplin (1977); W. Thomas Morgan, Jr., West Plains (1977); W. Wayne Boydston, Odessa (1977); H. Peter Ekern, Mexico (1978); Richard Hedges, Excelsior Springs (1978); M. Kenton King, St. Louis (1978); Roland E. Lohmar, Columbia (1978).

Medical-Legal Affairs—Irving H. Clark, Kansas City, Chairman (1977); David W. Brown, Springfield (1976); Francis X. Paletta, St. Louis (1976); Frederick J. McCoy, Kansas City (1976); Bernard Draper, Rolla (1976); Robert L. Willcoxon, Joplin (1976); Joseph C. Cope, Lexington (1977); Jerome I. Simon, St. Louis (1977); Vicente D. Deles, Crystal City (1977); George P. Wilson, Columbia (1977); Harold B. Rapp, Cape Girardeau (1978); William R. McPhee, Kansas City (1978); George L. Hawkins, Jr., St. Louis (1978); Noel R. Weyerich, Chesterfield (1978); Richard O. Craig, St. Joseph (1978).

Interspecialty Medicine—Missouri State Surgical Society, Cyril Costello, St. Louis, Chairman; Missouri State Allergy Association, Jean A. Chapman, Cape Girardeau; Missouri Society of Anesthesiologists, Donald J. Dickler, St. Louis; Missouri Dermatological Society, Larry Millikan, Columbia; Missouri ENT Association, Forrest H. Kendall, Prairie Village, Kansas; Missouri Academy of Family Physicians, Lois C. Wyatt, Kirkwood; Missouri Society of Internal Medicine, Robert Bregant, Jefferson City; Missouri Society of Neurosurgeons, August W. Geise, St. Louis; Missouri OB-GYN Society, Wallace Stacey, Independence; Missouri Ophthalmological Society, Anwar Shah, St. Louis; Missouri Orthopedic Association, Glenn L. McElroy, Columbia; Missouri Society of Pathologists, Henry C. Allen, St. Louis; Missouri Chapter, American Academy of Pediatrics, Don Overend, Springfield; Physical Medicine and Rehabilitation, Franz U. Steinberg, St. Louis; Missouri Radiological Society, William H. McAlister, St. Louis; Thoracic Surgical Society, Charles L. Roper, St. Louis; Federation of Missouri Urologists, Karl J. Kurtz, Kansas City; Missouri Psychiatric Association, Robert Brookes, St. Louis; Missouri Chapter of Society of Neurosciences, E. Robert Schultz, St. Louis; Missouri Thoracic Society, Florence E. MacInnis, Kansas City; Missouri Chapter, American College of Surgeons, G. Lynn Krause, St. Louis.

Councilor Districts and Counties in Each District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ST. LOUIS CITY
ATCHISON
NODAWAY
WORTH
HOLT
GENTRY
ANDREW
HARRISON
MERCER
DEKALB
DAVIESS
GRUNDY
CLINTON
BUCHANAN
PLATTE
CALDWELL
LIVINGSTON
CLAY
RAY
CARROLL
PUTNAM
SCOTLAND
SCHUYLER
SULLIVAN
CLARK
KNOX
LEWIS
ADAIR
LINN
SHELBY
MARION
CHARITON
MACON
MONROE
RANDOLPH
RALLS
PIKE
LINCOLN
JACKSON
LAFAYETTE
SALINE
HOWARD
BOONE
AUDRAIN
CALLAWAY
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ST. CHARLES
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ST. LOUIS
JOHNSON
PETTIS
CASS
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MONITEAU
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JEFFERSON
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MILLER
MARIES
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ST. CLAIR
CAMDEN
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HICKORY
DALLAS
LACLEDE
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POLK
BARTON
DADE
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TEXAS
JASPER
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WRIGHT
SHANNON
WAYNE
BOLLINGER
SCOTT
LAWRENCE
CHRISTIAN
DOUGLAS
HOWELL
CARTER
STODDARD
NEWTON
BARRY
STONE
TANEY
OZARK
OREGON
RIPLEY
BUTLER
MISSISSIPPI
McDONALD
NEW MADRID
PEMISCOT
DUNKLIN

Adjacent counties with like markings are component members of hyphenated medical societies.

DISTRICT	COUNCILOR	COUNTIES
First	**John N. Martin, M.D.** (Vice-Chairman) St. Joseph	Andrew, Atchison, Buchanan, Caldwell, Carroll, Clay, Clinton, Daviess, De Kalb, Gentry, Grundy, Harrison, Holt, Linn, Livingston, Mercer, Nodaway, Platte and Worth
Second	**J. Russell Comer, M.D.** Hannibal	Adair, Chariton, Clark, Knox, Lewis, Macon, Marion, Monroe, Pike, Putnam, Ralls, Randolph, Schuyler, Scotland, Shelby and Sullivan
Third	**Donald R. Judd, M.D.** St. Louis	St. Louis (City)
Fourth	**Louis P. Hetlage, M.D.** Troy	Franklin, Gasconade, Jefferson, Lincoln, St. Charles, St. Louis (County) and Warren
Fifth	**Robert E. Bregant, M.D.** Jefferson City	Audrain, Boone, Callaway, Camden,* Cole, Cooper, Howard, Miller, Moniteau, Montgomery, Morgan and Osage*
Sixth	**William D. Bradshaw, M.D.** Clinton	Bates, Benton, Cass, Cedar, Henry, Johnson, Lafayette, Pettis, Ray, St. Clair, Saline and Vernon
Seventh	**Andrew McCanse, M.D.** Kansas City	Jackson
Eighth	**Howard J. McAlhany, M.D.** (Chairman) Springfield	Barry, Barton, Christian, Dade, Dallas, Greene, Hickory, Jasper, Lawrence, McDonald, Newton, Polk, Stone, Taney and Webster
Ninth	**Claude W. Cooper, M.D.** Thayer	Crawford, Dent, Douglas, Howell, Laclede, Maries, Oregon, Ozark, Phelps, Pulaski, Shannon, Texas and Wright
Tenth	**Eugene T. Hansbrough, M.D.** Poplar Bluff	Bollinger, Butler, Cape Girardeau, Carter, Dunklin, Iron, Madison, Mississippi, New Madrid, Pemiscot, Perry, Reynolds, Ripley, St. Francois, Ste. Genevieve, Scott, Stoddard, Washington and Wayne

---

* Counties with no medical organization.

Component Societies in Affiliation With the Missouri State Medical Association

County	District	President	Address	Secretary	Address
Andrew	1	Gilbert B. Kelley	Savannah	Warren C. Baker	Savannah
Audrain	5	Harold D. Lankford	Mexico	John M. Boyce	Mexico
Barton	8			Thomas W. Carroll	Lamar
Boone	5	George P. Wilson	Columbia	Hugh S. Harris, Jr.	Columbia
Buchanan	1	William B. O'Connor	St. Joseph	Carl K. Ness	St. Joseph
Butler-Wayne-Ripley-Carter	10	Tom Wood	Poplar Bluff	Bennie N. Till	Poplar Bluff
Callaway	5	Henry Durst	Fulton	Katherine S. Brown	Fulton
Cape Girardeau	10	Edwin K. Burford, Jr.	Cape Girardeau	Paul C. Horn	Cape Girardeau
Chariton-Macon-Monroe-Randolph	2	Josephine Baker	Moberly	Robert Tompson	Moberly
Clay	1	Richard C. Hedges	Excelsior Springs	William D. Soper	Excelsior Spirngs
Clinton	1	Larry A. Ozenberger	Plattsburg	Paul T. Luckenbill	Plattsburg
Cole	5	Larry P. Courter	Jefferson City	Joseph Werth	Jefferson City
Cooper	5	Daikichi Hata	Boonville	E. T. Humphreys	Boonville
Dallas-Hickory-Polk-Dade	8	George Robinson	Humansville	Monte R. Kahler	Bolivar
Dunklin	10	Jun-Shen Huang	Kennett	Quinton Tarver	Kennett
Franklin-Gasconade-Warren	4	Charles H. Sincox	Washington	Carl Aulenbacher	Washington
Grand River Medical Society (Caldwell-Carroll-Livingston-Grundy-Daviess-Harrison-Linn-Mercer-DeKalb)	1	John R. Dixon	Brookfield	Hermanito R. Trinidad	Chillicothe
Greene	8	Michael J. Clarke	Springfield	R. Wayne Shelton	Springfield
Henry	6	Richard H. King	Clinton	Kenneth Scott	Clinton
Howard	5	William G. Marshall	Glasgow	M. P. Leech	Fayette
Jackson	7	Warren F. Wilhelm	Kansas City	T. J. Bryant	Kansas City
Jasper	8	Joe L. Longenecker	Joplin	M. A. S. Hallaba	Joplin
Jefferson	4	J. Logan Mayfield	Crystal City	Vicente D. Deles	Crystal City
Johnson	6	T. Reed Maxson	Warrensburg	Jerry Ragland	Warrensburg
Lafayette-Ray	6	Manit Vajaranant	Lexington	W. Wayne Boydston	Odessa
Lewis-Clark-Scotland	2			Landis Y. Davis	Canton
Marion-Ralls-Shelby	2	Robert W. Buben	Hannibal	Federico N. Florendo, Jr.	Hannibal
Mid-Missouri County Medical Society (Phelps-Crawford-Dent-Pulaski-Maries-Laclede)	9			Bernard Draper	Rolla
Miller	5	Carl T. Buehler, Jr.	Eldon	Edward O. Shelton	Eldon
Mineral Area Medical Society (St. Francois-Iron-Madison-Washington-Reynolds-Bollinger)	10	Norma D. Farmer	Farmington	Charles W. Chastain	Farmington
Moniteau	5	Kenyon S. Latham	California	Lionel M. Gallagher	California
Montgomery	5			S. J. Byland	Wellsville
Morgan	5	Ruth Kauffman	Versailles	C. Robert Hall	Versailles
North Central Counties Medical Society (Adair-Schuyler-Knox-Sullivan-Putnam)	2	Francis Tarvydas	Edina	Milton T. English	Kirksville
Northwest Missouri Medical Society (Nodaway-Holt-Atchison-Gentry-Worth)	1	Robert E. Dunshee	Maryville	Frank B. Matteson	Grant City
Ozarks Medical Society (Barry-Lawrence-Stone-Christian-Taney-Newton-McDonald)	8	Francisco R. Esparrago, Jr.	Monett	Arthur J. Graves	Mt. Vernon
Pemiscot	10	James Grable	Portageville	Clarence W. McKaskle	Caruthersville
Perry-Ste. Genevieve	10	Job E. Pontillas	Perryville	Alfred E. McDermott	Perryville
Pettis	6	Alvin L. Lowe	Sedalia	Harold F. Daum	Sedalia
Pike	2	Charles H. Lewellen	Louisiana	Mathew L. Nichels	Louisiana
Platte	1	Paul C. Vescovo	Kansas City		
St. Charles-Lincoln	4	Tsutomu Kamada	O'Fallon	James L. Carpenter	St. Charles
St. Louis Medical Society	3	August W. Geise, Jr.	St. Louis	Leslie F. Bond	St. Louis
St. Louis County Medical Society	4	John M. Laird	Florissant	Edwin J. Cunningham	Ballwin
Saline	6			B. F. Knipschild	Marshall
SEMO County Medical Society (Stoddard-New Madrid-Mississippi-Scott)	10	Jesse W. Page	Sikeston	Daniel Rosenstein	Sikeston
South Central (Howell-Oregon-Texas-Wright-Douglas-Ozark)	9	C. Franklin Smith	Willow Springs	W. T. Morgan, Jr.	West Plains
Webster	8	T. M. Macdonnell	Marshfield	Robert J. Bareis	Marshfield
West Central Missouri Medical Society (Bates-Cass-Cedar-St. Clair-Vernon)	6	Glen H. Reed	Appleton City	R. John Torontow	Nevada

Guide to County Medical Societies

Following is a list of Missouri communities in which MSMA member-physicians are in active practice or reside. Name of the community is followed by the county in which it is located and the medical society to which physicians of that community normally would belong.

A

Town	*County*	*Medical Society*
Advance	Stoddard	SEMO
Affton	St. Louis*	
Albany	Gentry	Northwest Missouri
Altenburg	Perry	Perry-Ste. Genevieve
Appleton City	St. Clair	West Central
Arnold	Jefferson	Jefferson
Ashland	Boone	Boone
Aurora	Lawrence	Ozarks
Ava	Douglas	South Central

B

Town	*County*	*Medical Society*
Ballwin	St. Louis*	
Belton	Cass	West Central
Berkeley	St. Louis*	
Bethany	Harrison	Grand River
Bloomfield	Stoddard	SEMO
Blue Springs	Jackson	Jackson
Bolivar	Polk	Dallas-Hickory-Polk-Dade
Bonne Terre	St. Francois	Mineral Area
Boonville	Cooper	Cooper
Bourbon	Crawford	Mid-Missouri
Bowling Green	Pike	Pike
Branson	Taney	Ozarks
Braymer	Caldwell	Grand River
Brentwood	St. Louis*	
Bridgeton	St. Louis*	
Brookfield	Linn	Grand River
Browning	Linn	Grand River
Brunswick	Chariton	Chariton-Macon-Monroe-Randolph
Buckner	Jackson	Jackson
Buffalo	Dallas	Dallas-Hickory-Polk-Dade
Butler	Bates	West Central

C

Town	*County*	*Medical Society*
Cabool	Texas	South Central
Cainesville	Harrison	Grand River
California	Moniteau	Moniteau
Camdenton	Camden	Camden
Cameron	Clinton	Clinton
Cape Girardeau	Cape Girardeau	Cape Girardeau
Cardwell	Dunklin	Dunklin
Carrollton	Carroll	Grand River
Carthage	Jasper	Jasper
Caruthersville	Pemiscot	Pemiscot
Cassville	Barry	Ozarks
Centralia	Boone	Boone
Charleston	Mississippi	SEMO
Chesterfield	St. Louis*	
Chillicothe	Livingston	Grand River
Clarksville	Pike	Pike
Clayton	St. Louis*	
Clinton	Henry	Henry
Columbia	Boone	Boone
Concordia	Lafayette	Lafayette-Ray
Crane	Stone	Ozarks
Creve Coeur	St. Louis*	
Crystal City	Jefferson	Jefferson
Cuba	Crawford	Mid-Missouri

D

Town	*County*	*Medical Society*
Desloge	St. Francois	Mineral Area
DeSoto	Jefferson	Jefferson
Dexter	Stoddard	SEMO
Doniphan	Ripley	Butler-Wayne-Ripley

E

Town	*County*	*Medical Society*
East Prairie	Mississippi	SEMO
Edina	Knox	North Central
Eldon	Miller	Miller
El Dorado Springs	Cedar	West Central
Elsberry	Lincoln	St. Charles-Lincoln
Everton	Jackson	Jackson
Excelsior Springs	Clay	Clay

F

Town	*County*	*Medical Society*
Farmington	St. Francois	Mineral Area
Fayette	Howard	Howard
Fenton	St. Louis*	
Ferguson	St. Louis*	
Festus	Jefferson	Jefferson
Flat River	St. Francois	Mineral Area
Florissant	St. Louis*	
Forsyth	Taney	Ozarks
Fort Leonard Wood	Pulaski	Mid-Missouri
Fredericktown	Madison	Mineral Area
Frontenac	St. Louis*	
Fulton	Callaway	Callaway

G

Town	*County*	*Medical Society*
Gallatin	Daviess	Grand River
Gashland	Clay	Clay
Gerald	Franklin	Franklin-Gasconade-Warren
Gideon	New Madrid	SEMO
Gladden	St. Louis*	
Glasgow	Howard	Howard
Glendale	St. Louis*	
Grandview	Jackson	Jackson
Grant City	Worth	Northwest Missouri
Gravois Mills	Morgan	Morgan
Greenfield	Dade	Barton-Dade

H

Town	*County*	*Medical Society*
Hamilton	Caldwell	Grand River
Hannibal	Marion	Marion-Ralls-Shelby
Harrisonville	Cass	West Central
Hayti	Pemiscot	Pemiscot
Herculaneum	Jefferson	Jefferson
Hermann	Gasconade	Franklin-Gasconade-Warren
Hickman Mills	Jackson	Jackson
Higginsville	Lafayette	Lafayette-Ray
Hillsboro	Jefferson	Jefferson
Hornersville	Dunklin	Dunklin
Houston	Texas	South Central
Humansville	Polk	Dallas-Hickory-Polk-Dade
Huntsville	Randolph	Chariton-Macon-Monroe-Randolph

I

Town	*County*	*Medical Society*
Illmo	Cape Girardeau	Cape Girardeau
Independence	Jackson	Jackson
Ironton	Iron	Mineral Area

J

Town	*County*	*Medical Society*
Jackson	Cape Girardeau	Cape Girardeau
Jefferson Barracks	St. Louis*	
Jefferson City	Cole	Cole
Jennings	St. Louis*	
Joplin	Jasper	Jasper

K

Town	*County*	*Medical Society*
Kansas City	Jackson	Jackson
Kennett	Dunklin	Dunklin
King City	Gentry	Northwest Missouri
Kirksville	Adair	North Central
Kirkwood	St. Louis*	
Knob Noster	Johnson	Johnson
Knox City	Knox	North Central
Koch	St. Louis*	

L

Town	*County*	*Medical Society*
Ladue	St. Louis*	
Lamar	Barton	Barton
Lawson	Ray	Lafayette-Ray
Leawood (Kan.)		Jackson
Leadwood	St. Francois	Mineral Area

*** Member may belong to St. Louis County Medical Society or St. Louis Medical Society.**

Town	*County*	*Medical Society*
Lebanon	Laclede	Mid-Missouri
Lee's Summit	Jackson	Jackson
Lemay	St. Louis*	
Lexington	Lafayette	Lafayette-Ray
Liberty	Clay	Clay
Lockwood	Dade	Dallas-Hickory-Polk-Dade
Louisiana	Pike	Pike
M		
Macon	Macon	Chariton-Macon-Monroe-Randolph
Malden	Dunklin	Dunklin
Maplewood	St. Louis*	
Marceline	Linn	Grand River
Marshall	Saline	Saline
Marshfield	Webster	Webster
Martin City	Jackson	Jackson
Maryville	Nodaway	Northwest Missouri
Memphis	Scotland	Lewis-Clark-Scotland
Mexico	Audrain	Audrain
Milan	Sullivan	North Central
Moberly	Randolph	Chariton-Macon-Monroe-Randolph
Monett	Barry	Ozarks
Montgomery City	Montgomery	Montgomery
Morehouse	New Madrid	SEMO
Mound City	Holt	Northwest Missouri
Mountain Grove	Wright	South Central
Mountain View	Howell	South Central
Mount Vernon	Lawrence	Ozarks
N		
Neosho	Newton	Ozarks
Nevada	Vernon	West Central
New Florence	Montgomery	Montgomery
New Haven	Franklin	Franklin-Gasconade-Warren
New London	Ralls	Marion-Ralls-Shelby
New Madrid	New Madrid	SEMO
Normandy	St. Louis*	
North Kansas City	Clay	Clay
O		
Oak Grove	Jackson	Jackson
Odessa	Lafayette	Lafayette-Ray
O'Fallon	St. Charles	St. Charles-Lincoln
Olivette	St. Louis*	
Osceola	St. Clair	West Central
Overland	St. Louis*	
Owensville	Gasconade	Franklin-Gasconade-Warren
Ozark	Christian	Ozarks
P		
Pacific	Franklin	Franklin-Gasconade-Warren
Palmyra	Marion	Marion-Ralls-Shelby
Paris	Monroe	Chariton-Macon-Monroe-Randolph
Parkville	Platte	Platte
Parma	New Madrid	SEMO
Pattonsburg	Daviess	Grand River
Pattonville	St. Louis*	
Perryville	Perry	Perry-Ste. Genevieve
Piedmont	Wayne	Butler-Wayne-Ripley
Pine Lawn	St. Louis*	
Platte City	Platte	Platte
Plattsburg	Clinton	Clinton
Pleasant Hill	Cass	West Central
Poplar Bluff	Butler	Butler-Wayne-Ripley
Portageville	New Madrid	SEMO
Potosi	Washington	Mineral Area
Prairie Village (Kan.)		Jackson
Princeton	Mercer	Grand River
R		
Raytown	Jackson	Jackson
Reeds Spring	Stone	Ozarks
Republic	Greene	Greene
Rich Hill	Bates	West Central
Richmond	Ray	Lafayette-Ray
Richmond Heights	St. Louis*	
Rivermines	St. Francois	Mineral Area
Robertson	St. Louis*	
Rock Hill	St. Louis*	
Rockport	Atchison	Northwest Missouri
Rogersville	Webster	Webster
Rolla	Phelps	Mid-Missouri
S		
St. Ann	St. Louis*	
St. Charles	St. Charles	St. Charles-Lincoln
St. Clair	Franklin	Franklin-Gasconade-Warren
Ste. Genevieve	Ste. Genevieve	Perry-Ste. Genevieve
St. James	Phelps	Mid-Missouri
St. Joseph	Buchanan	Buchanan
St. Louis City*		
Salem	Dent	Mid-Missouri
Salisbury	Chariton	Chariton-Marion-Monroe-Randolph
Sappington	St. Louis*	
Sarcoxie	Jasper	Jasper
Savannah	Andrew	Andrew
Sedalia	Pettis	Pettis
Shawnee Mission (Kan.)		Jackson
Shelbina	Shelby	Marion-Ralls-Shelby
Shelbyville	Shelby	Marion-Ralls-Shelby
Shrewbury	St. Louis*	
Sikeston	Scott	SEMO
Slater	Saline	Saline
Smithton	Pettis	Pettis
Smithville	Clay	Clay
Springfield	Greene	Greene
Stanberry	Gentry	Northwest Missouri
Steele	Pemiscot	Pemiscot
Steelville	Crawford	Mid-Missouri
Stockton	Cedar	West Central
Strafford	Greene	Greene
Sullivan	Franklin	Franklin-Gasconade-Warren
Sweet Springs	Saline	Saline
T		
Tarkio	Atchison	Northwest Missouri
Thayer	Oregon	South Central
Trenton	Grundy	Grand River
Troy	Lincoln	St. Charles-Lincoln
U		
Union	Franklin	Franklin-Gasconade-Warren
University City	St. Louis*	
V		
Valley Park	St. Louis*	
Vandalia	Audrain	Audrain
Versailles	Morgan	Morgan
W		
Warrensburg	Johnson	Johnson
Warrenton	Warren	Franklin-Gasconade-Warren
Warsaw	Benton	Benton
Washington	Franklin	Franklin-Gasconade-Warren
Waverly	Lafayette	Lafayette-Ray
Waynesville	Pulaski	Mid-Missouri
Webb City	Jasper	Jasper
Webster Groves	St. Louis*	
Wellsville	Montgomery	Montgomery
Wentzville	St. Charles	St. Charles-Lincoln
West Plains	Howell	South Central
Willard	Greene	Greene
Willow Springs	Howell	South Central
Windsor	Henry	Henry
Winona	Shannon	Carter-Shannon
Winston	Daviess	Grand River

*** Member may belong to St. Louis County Medical Society or St. Louis Medical Society.**

Alphabetical Roster of Members

(See Instructions on Page 403)

A

aron, George A., Independence
badir, Rushdy, Columbia
baqueta, Gamaliel P., Kansas City
bdou, Nancy L., Kansas City
bel, Charles C., St. Louis
bel, Oliver, III, St. Louis
bele, Wm. A., Boonville
belardo, Miguel L., St. Louis
bell, Walter E., St. Louis
bella, Bienvenido Z., Kansas City
bend, Melvin N., Kansas City
bercrombie, Keith J., Kansas City
binoja, Conrado B., St. Louis
brams, Bernard M., Kansas City
brams, Morris, St. Louis
bramson, Charles L., St. Louis
cker, Harry L., St. Louis
ckerman, Lauren V., St. Louis
cuff, R. Phillip, St. Joseph
dams, Harold D., Columbia
dams, Howard D., Liberty
dams, Robert B., Jr., Joplin
debimpe, Victor R., St. Louis
delman, Arthur, Kansas City
deyemi-Doro, Henry, St. Louis
dler, Benard C., St. Louis
dler, Federico, Kansas City
fuwape, Emmanuel, St. Louis
gasino, Armela R., St. Louis
gasino, Gaudencio, Sullivan (Member St. Louis Medical Society)
gee, Loren G., Kansas City
gress, Harry, St. Louis
guinaldo, Jaime A.. St. Louis
had, Abdul, St. Joseph
hadi, Abd Ul Ahad, St. Louis
hern, Archibald M., St. Louis
hlering, George H., St. Louis
hlvin, Robert C., Sikeston
hmad, Bashir, St. Louis
Ahuja, A. L., St. Louis
itken, Louis F., St. Louis
Ajans, Z. A., Mexico
Aker, Umit, St. Louis
Aks, Daniel, Kansas City
Akyol, Salim, St. Louis
Albano, Benjamin I., Crystal City
Albera, Victor H., St. Louis
Alberg, Marvin R., Kansas City
Alderman, Donald P., Shawnee Mission, Kan. (Member Jackson County Medical Society)
Alderman, Thomas F., Kansas City
Alegre, Jorge M., St. Louis
Aleksander, Bernardo, St. Louis
Alex, Morris, St. Louis
Alexander, France, St. Louis
Alexander, Frazier D., St. Louis
Alexander, George K., Ballwin
Alisuag, Andres, Jr., St. Charles
Allain, James J., North Kansas City
Allan, James E., Jefferson City
Allan, James R., Liberty
Allbee, Roger H.. Crystal City
Allcorn, Donald J., Columbia
Allebach, Hobart K., Kansas City
Allen, Claude J., Rich Hill
Allen, David O., Joplin
Allen, E. Warren, Carrollton
Allen, Henry C., St. Louis
Allen, Hollis N., St. Louis
Allen, James H., St. Louis
Allen, Jerry H., Springfield
Allen, Joseph E., Columbia
Allen, Louis A., Kansas City
Allen, Melvin A., St. Louis
Allen, Robert E., Kansas City
Allen, Robert W., Columbia
Allen, S. Lloyd, Kansas City
Allen, Stephen C., Springfield
Allen, Willard M., Baltimore, Md. (Member St. Louis Medical Society)
Allen, William C., Columbia
Allen, William E., Jr., St. Louis
Allen, William H., Nevada
Allison, James B., Springfield
Almiron, Osias A., Maryland Heights
Almond, Carl H., Columbia
Alonso, Jose Mario V., Jr., St. Louis
Alonso, William A., St. Louis
Alonso-Yague, P., St. Louis
Alsop, Webb S., Jr., Kansas City
Althaus, Carl Jacob, Ballwin
Altheide, Harvey E., Ladue
Altheide, J. Paul, St. Louis
Altman, Marvin P., St. Charles
Altomare, Edward P., Kansas City
Alul, Michael, St. Charles
Alvarez, Luis L., St. Louis
Alvarez, Ulises C., St. Louis
Alvis, Bennett Y., St. Louis
Alvis, Edmund B., St. Louis
Alyea, J. O., Cape Girardeau
Amado-Ledo, David E., St. Louis
Ames, Mary B., Columbia (Member Jackson County Medical Society)
Ames, William H., St. Joseph
Amin, Avora M., St. Louis
Amin, Navinkumar J., St. Louis
Amjad, Mohammad T., Ballwin
Ammatelli, Francis J., Kansas City
Amoury, Raymond A., Kansas City
Analkat, H. N., St. Louis
Ancheta, Apolinario A., Springfield
Anderson, Charles B., St. Louis
Anderson, Ivan A., Columbia
Anderson, John M., St. Louis
Anderson, Paul B., Neosho
Anderson, Philip C., Columbia
Anderson, Raymond B., Kansas City
Anderson, Thomas R., Columbia
Andreassen, Dimil F., Rolla
Andres, Edward H., St. Joseph
Andrews, Berneil W., N. Kansas City (Member Clay County Medical Society)
Andrus, Bailey C., Kansas City
Angelillo, John C., Florissant
Angelo, Thomas L., Manchester
Anglo, Luis B., St. Louis
Ansari, Ansar H., Pittsfield, Ill. (Member St. Louis Medical Society)
Anslinger, David I., St. Louis
Anstey, George, St. Ann
Anthony, Dallas, Springfield
Anthony, Elwyn J., St. Louis
Antoniou, Christos, St. Ann
Apostol, Andres G., Monett
Appleberry, Charles H., Rivermines
Aquino, Philip J., Caruthersville
Arana, Victor A., Falls City, Neb. (Member Callaway County Medical Society)
Arat, Metin, Battle Creek, Mich. (Member Mineral Area County Medical Society)
Arbab, Ali A., Kansas City
Archer, Carol R., St. Louis
Arenberg, Irving K., St. Louis
Arenos, Proceso T., Jr., St. Louis
Arias, Fernando, St. Louis
Arms, Arnold V., Kansas City
Armstrong, Jay H., Shawnee Mission, Kan. (Member Clay County Medical Society)
Arneson, Axel N., St. Louis
Arney, William G., St. Louis
Arnold, Eugene L., St. Louis (Member Chariton-Macon-Monroe-Randolph County Medical Society)
Arnold, Herbert M., Lamar
Arnold, John D., Kansas City
Arnold, Kenneth J., St. Louis
Arnold, Richard C., Columbia
Aronson, Abraham, St. Louis
Arnot, John P., St. Louis
Arribas, Aurora I., Buckner
Arribas, Neva P., St. Louis
Arribas, Romeo F., Blue Springs
Arst, Herbert E., Kansas City (Member Clay County Medical Society)
Aschman, Theodore H., Kansas City
Asel, Norman D., Columbia
Ash, Charles J., Springfield
Ashby, Jennifer D., Kansas City
Ashcraft, Keith W., Kansas City
Asher, A. Graham, Kansas City
Ashley, Hugh V., Cape Girardeau
Ashley, Thomas F., Springfield
Askew, John H., Sikeston
Asnani, Mithlesh G., Kansas City
Atcheson, Windsor B., Trenton
Atkinson, Thomas E., Jr., Springfield
Atwell, Floyd C., Kansas City
Auer, Arthur I., St. Louis
Auer, Edward T., St. Louis
Aufderheide, G. Russell, St. Louis
Auguste, Jean Meledain, St. Louis
Augustin, Cesar, St. Louis
Aulenbacher, Carl E., Washington
Auner, Cecil R., Springfield
Averill, Keith H., Kansas City
Avery, Willard B., Boonville
Avila, Estrella Z., Hannibal
Avila, Patricio C., Hannibal
Avioli, Louis V., St. Louis
Ayata, Sedat M., St. Louis
Aykent, Yavuz, St. Louis
Aylward, Howard J., St. Louis
Aylward, Howard J., Jr., Columbia
Ayotte, Nancy C., Kansas City
Ayvazian, Vatche H., St. Louis
Azuma, Nobutaka, St. Louis
Azzouni, J. N., High Ridge

B

Babka, Joseph J., St. Louis
Babu, Sylvia S., Kansas City
Bach, Lysle M., Hannibal
Back, Donald K. Springfield
Backer, Matthias H., Jr., St. Louis
Badger, Virginia M., St. Louis
Baer, Alvin J., Kansas City
Bagby, James W., Clayton
Bagwe, Lata R., St. Louis
Bahn, Charles F., Cape Girardeau
Bai, Sangzin, Festus
Baik, Kil Young, Waverly
Bailey, Alan H., Springfield
Bailey, Drennan, St. Louis
Bailey, William H., St. Louis
Baird, Keim L., St. Charles
Baja, Arun R., Poplar Bluff
Baker, A. Sherwood, Columbia
Baker, Donald L., Union
Baker, James M., Columbia
Baker, Josephine D., Moberly
Baker, Philip J., Independence
Baker, Warren C., Savannah
Baldwin, Richard, Springfield
Baldwin, Richard, Jr., St. Louis
Baldwin, Theodore R., Excelsior Springs
Bales, Eugene L., Carrollton
Balhuizen, John, Kansas City
Ballal, H. S., St. Louis
Ballard, V. Bryce, Kansas City
Ballinger, Walter F., II, St. Louis
Balster, Vernon H., St. Louis
Bamshad, Jerry, Florissant
Bandle, Donald F., St. Louis
Banet, Samuel R., St. Louis
Banjastikul, Chusak, St. Louis
Bankuti, Ferenc, Kansas City
Banton, M. Roman, St. Louis
Banton, Thomas J., St. Louis
Banton, William C., St. Louis
Barbee, Charles W., Columbia
Barbero, Gilulio J., Columbia
Barbour, Marvin R., Poplar Bluff
Bardsley, John L., St. Louis
Bare, Chester I., Jr., Kansas City
Bare, Edward F., Tarkio
Bareis, Robert J., Marshfield
Barelli, Pat A., Kansas City
Barker, Edward T., St. Louis
Barloon, James H., Kansas City
Barnard, John L., Jr., Kansas City
Barner, Hendrick, St. Louis
Barnes, Asa, Jr., Columbia
Barnes, Seth S., Cape Girardeau
Barnett, Charles H., Bolivar
Barnett, Floyd A., Paris
Barnett, Gordon P., Shawnee Mission, Kan. (Member Jackson County Medical Society)
Barnhill, Floyd R., Springfield
Barone, Paul L., Nevada
Barr, Glenn A., Kansas City
Barragan, Hector, Ballwin
Barrett, Scott R., St. Louis
Barrow, Jack, St. Louis
Barry, Gerald W., Kansas City
Barry, William B., Kansas City
Bartlett, Robert W., St. Louis
Bartley, Richard L., Springfield
Bartnick, Mitchel L., De Soto (Member St. Louis Medical Society)
Barton, Leslie L., St. Louis
Barton, Robert W., St. Louis
Bartulica, Nicholas, St. Joseph
Basantz, Fernando V., Kansas City
Baska. R. E.. Kansas Citv
Bass, Lewis N., Kansas City
Bass, Walter R., Kansas City
Bates, George C., N. Kansas City (Member Clay County Medical Society)
Battmer, Robert E., Kansas City
Baue, Arthur E., St. Louis

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* Doctor of Osteopathy.

Bauer, Eugene A., St. Louis
Bauer, Harold A., Springfield (Member Dallas-Hickory-Polk-Dade County Medical Society)
Bauer, John D., St. Louis
Bauer, Joseph A., St. Louis
Bauer, Lafe W., Prairie Village, Kan. (Member Jackson County Medical Society)
Bauer, Maria, Granite City, Ill. (Member St. Louis Medical Society)
Bauer, Otto, Granite City, Ill. (Member St. Louis Medical Society)
Bauer, Robert A., St. Louis
Baula, Armindo G., St. Louis
Baum, Frank E., Kansas City
Bauman, Henry C., Maryville
Baumann, A. R., Steelville
Baumgarten, Walter, Jr., St. Louis
Bauschard, Frederick, St. Louis
Bautista, Rogelio L., Moberly
Bay, Merrill R., Blue Springs
Bayer, William L., Kansas City
Bayrakdar, Admad K., St. Louis
Bazzano, Gaetano, St. Louis
Bealer, Louis A., Lebanon
Beall, M. Scott, Kansas City
Beard, William J., Lee's Summit
Beare, J. Byron, St. Louis
Beasley, L. Kenneth, Port Salerno, Fla. (Member St. Louis County Medical Society)
Beato, David L., St. Louis
Beatty, Arch J., Kansas City
Beatty, Eugene C., Kansas City
Beatty, Nina D., Kansas City
Beaty, William R., St. Louis
Beck, Calvin E., Kansas City
Beck, Paul M., St. Joseph
Becker, Bernard, St. Louis
Becker, Edward J., St. Louis
Becker, Richard R., Kansas City
Becker, Rolfe A., Kansas City
Becker, Stanley C., St. Louis
Beckette, Edmund S., Florissant
Beckloff, Gerald L., Kansas City
Beckman, Donald E., St. Louis
Beecher, Sheldon B., Poplar Bluff
Beeks, John W., Kansas City (Member Clay County Medical Society)
Beers, Alvin, Jr., St. Louis
Beheler, Edward M., St. Joseph
Behrends, Steven H., Kansas City
Behrens, Donald T., St. Louis
Behrens, Gerald L., St. Louis
Beidle, Raymond J., St. Ann
Beisner, Donald H., Springfield
Belancourt, Dunet F., St. Louis
Belden, Edgar A., Jefferson City
Belew, Joe E., St. Louis
Bell, Hubert H., Kansas City
Bell, Martin J., St. Louis
Bell, Robert M., Hannibal (Member St. Louis Medical Society)
Bell, William F., Lee's Summit
Benage, Clarence M., Florissant
Bennett, James D., Kansas City
Bennett, Kenneth J., St. Louis
Benoit, Hector Wright, Jr., Kansas City
Benson, John F., St. Louis
Benson, Larry E., Kansas City (Member Clay County Medical Society)
Benson, Leo J., Jr., Kennett
Benson, Ronald G., Springfield
Benson, Scott C., St. Joseph
Benson, William F., Kansas City
Bentinganan, Victor D., Fredericktown
Bentlage, Charles H., Joplin
Bentley, John D., Springfield
Berard, Louis N., St. Louis
Berenson, Sheldon E., Kansas City
Berg, Edward F., Ladue
Berg, Leonard, St. Louis
Berg, Ralph, St. Louis
Berger, Edward J., St. Louis
Bergman, Hugo F., St. Louis
Bergmann, Dwayne, St. Louis
Bergmann, John F., St. Louis
Bergmann, Martin, St. Louis
Bergmann, Victor H., Kansas City
Bergner, Grace E., St. Louis
Berland, Harry I., St. Louis
Berlin, Roger, Kansas City
Berman, William, St. Louis
Bernabe, Florinio H., Manchester
Bernabe, Ofelia M., Manchester
Bernard, J. W., Caruthersville
Berndsen, Gerard H., Rock Hill
Berney, Francis J., St. Joseph
Berni, Anthony A.. St. Louis
Bernreiter, Michael, Kansas City
Bernstein, Aaron M., Clayton
Berry, John W., St. Louis
Berry, Maxwell G., Kansas City
Berry, Paul T., Springfield
Bersche, Bertram L., St. Louis
Berwald, David M., Bridgeton
Berwald, Irwin I., St. Louis
Best, Robert, Overland Park, Kan. (Member Lafayette-Ray County Medical Society)
Bettonville, Paul J., Jr., St. Louis
Betz, Richard J., Neosho
Betz, Robert F., Neosho
Bhatara, Vinod S., St. Louis
Bhend, David P., Joplin
Bickel, Vern T., Lamar
Bickley, James E., Kansas City
Biddy, Ralph L., St. Louis
Bidwell, Robert E. G., Kansas City
Biery, Richard M., Kansas City
Biggs, Alfred D., Jr., Kansas City
Biggs, Fred J., Jr., Poplar Bluff
Biggs, Harry L., Kansas City
Bikales, Victor W., Kansas City
Bills, Marvin L., Kansas City
Billy, Lawrence J., St. Louis
Bilsky, Nathan, St. Louis
Bindbeutel, Donald A., St. Louis
Binder, Morton A., St. Louis
Bircher, John L., St. Louis
Bird, H. Waldo, St. Louis
Birenbaum, Aaron, St. Louis
Birge, Clifford A., St. Louis
Birsner, Frank H., Joplin
Bishop, Marion D., Florissant
Bishop, Mary M., St. Louis
Bisno, Daniel, St. Louis
Black, Don A., Kansas City
Black, Eugene C., Shawnee Mission, Kan. (Member Jackson County Medical Society)
Black, Samuel P. W., Columbia
Black, Thomas C., Jr., Kansas City
Blackman, Nathan, Kirkwood
Blackmore, Thomas A., Windsor
Blackwell, Charles R., Maryland Heights
Blackwell, Charles W., Columbia
Blades, Ross D., Springfield
Bladow, Terrence C., Joplin
Blair, John D., St. Louis
Blair, Olga M., St. Louis
Blair, Vilray P., Jr., St. Louis
Blalock, Robert W., Marshall
Blank, Michael K., DeSoto
Blankenship, Dale M., Cape Girardeau
Blankenship, George W., Neosho
Blanton. J. C., Sikeston
Blath, Richard A., St. Louis
Bleisch, Nadyak, St. Louis
Bleisch, Virgil R., St. Louis
Blim, Richard D., Kansas City
Bliss, Joy V., Excelsior Springs
Block, Arnold S., St. Louis
Block, J. E., Sedalia
Blount, Lee, Jr., St. Louis
Blythe, James, St. Louis
Boc, Inocencio M., St. Louis
Bockelman. Clifford H., Brentwood
Boedeker, Roy V., St. Louis
Boger, James W., Sedalia
Bohigian, George, St. Louis
Bohling, Corey A., St. Louis
Bohnsack, Ralph W., Brookfield
Boldizar, Albert G., St. Louis
Boldt, Thomas H., St. Louis
Boles, C. Read, Clayton
Bolinske, Robert E., Creve Coeur
Bollozos, George D., St. Louis
Bolton, Robert L., Ballwin
Bond, Leslie F., St. Louis
Bondurant, Bryce H., St. Louis
Bonebrake, M. D., Springfield
Bonfanti, Albert L., St. Louis
Bonifacio, Andres S., Crystal City
Boniuk, Isaac, St. Louis
Bonney, Samuel C., Washington
Bonsanti, Robert L., Bridgeton
Boone, Daniel C., Kansas City
Boone, Martin H., Jr., Springfield
Boonkham, C., St. Louis
Boonshaft, Benje, St. Louis
Boonyasai, Boonfu, Ironton
Booth, William V., Dexter
Bopp, Jon Ronald, Joplin
Bordy, Marvin D., Kansas City
Borenstine, Joseph, Kansas City
Borja, Egbert, Springfield
Borowsky, Benjamin A., St. Louis
Borromeo, Carlos J., Rivermines
Borsuk, Gregory M., Kansas City
Bortnick, Arthur R., St. Louis
Bortnick, Eugene, Kansas City
Botwin, Arnold E., Kansas City
Bourgeois, Curtis, Rocheport
Bourjolly, Wilson, St. Louis
Bourke, Thomas E., St. Louis
Boutros, Amin, Kansas City
Boveri, Joseph C., St. Louis
Bowdern, Edward H., Richmond Heights
Bowe, Edwin Earl, Jefferson City
Bowen, Stephen F., Jr., St. Louis
Bowerman, Harold H., St. Louis
Bowers, James E., Kirkwood
Bowersox, Warren A., Pacific (Member St. Louis Medical Society)
Bowles, G. Robert, St. Louis
Bowles, Richard P., Liberty
Bowles, William T., St. Louis
Bowman, Melvin C., Neosho
Bowman, William K., Cape Girardeau
Bowser, John F., Kansas City
Boyarsky, Saul, St. Louis
Boyce, John Milton, Mexico
Boyd, Arthur M., St. Louis
Boyd, George K., Kansas City
Boydston, Catherine, Odessa
Boydston, W. Wayne, Odessa
Boyer, Philip A., Jr., Lee's Summit
Boylan, Peter C., Kansas City
Bozzo, Raymond J., Washington
Braby, Howard H., Independence
Bradford, John F., Kansas City
Bradley, Richard V., Clayton
Bradley, William B., Jefferson City
Bradley, William W., Centralia
Bradshaw, W. D., Clinton
Brady, Harry R., St. Louis
Brady, Hugh S., Concordia
Brahmacupta, Nanthana, Excelsior Springs
Brams, Jack B., Kansas City
Brancato, Donald H., Florissant
Brand, Earl L., Webster Groves
Brandon, Frederick M., Joplin
Brangle, Robert W., St. Louis
Braufman, Harvey S., St. Louis
Braverman, Abe E., Kansas City
Braverman, Elliot M., Sedalia
Bravo, Cesar A., Kansas City
Brazos, John C., Smithton
Bregant, Robert E., Jefferson City
Bremer, Rita, St. Charles
Bremser, Harry L., St. Louis
Brennan, Daniel J., St. Louis
Brennan, George A., St. Louis
Brennan, Patricia A., St. Louis
Brennan, Raymond J., Chillicothe
Brennan, Robert A., St. Louis
Brennan, Robert V., St. Louis
Brenner, Paul A., Owensville
Brent, Lanny R., Springfield
Brereton, Robert L., Kirkwood
Brian, William J., Springfield
Brick, Jeffrey M., Kansas City
Bricker, Eugene M., Clarksville (Member St. Louis Medical Society)
Brion, Pacelli E., St. Louis
Briscoe, John R., St. Louis
Bristow, Robert B., St. Joseph
Brizio-Molteni, Loredana, N. Kansas City (Member Clay County Medical Society)
Broaddus, Loren, Springfield
Brodeur, Armand E., St. Louis
Bronson, Shael S., St. Louis
Brookes, Robert D., St. Louis
Brookreson, Alton D., Poplar Bluff
Brookreson, Alton F., Poplar Bluff
Brooks, John E., Springfield
Brother, George M., Clearwater, Fla. (Member St. Louis County Medical Society)
Broun, Goronwy O., St. Louis
Broun, Goronwy O., Jr., St. Louis
Brower, Clyde L., Independence
Brown, Adrian J., Kansas City
Brown, Daniel W., San Diego, Calif. (Member St. Louis Medical Society)
Brown, David W., Springfield
Brown, E. Eugene, St. Louis
Brown, Elwyn S., Kansas City
Brown, Frederick B., Aurora
Brown, Irwin S., Kansas City
Brown, James L., St. Louis
Brown, James M., St. Louis
Brown, James T., Springfield
Brown, John J., Fulton
Brown, Katherine S., Fulton
Brown, Menzie H., Kansas City
Brown, Robert S., Kansas City
Brown, Seymour, Chesterfield
Brown, Violeta O., Kansas City
Brownsberger, Robert H., Appleton City
Broyles, Watkins A., Bethany
Brubaker, Leonard L., Columbia
Bruce, Helen L., St. Louis
Bruce, Leo A., Sikeston
Bruce, Robert M., St. Louis
Brugger, Thomas, St. Louis

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Brukardt, Diane, Columbia
Brumm, Lawrence W., Kansas City
Bruner, Claude R., Camdenton (Member Boone County Medical Society)
Bruner, Robert E., Kansas City
Bruns, Kenneth, St. Louis
Brust, Carl H., Mission, Kan. (Member Jackson County Medical Society)
Bryan, James H., Clayton
Bryan, William H., Jr., Kansas City
Bryan, William T. K., St. Louis
Bryant, Sydney L., St. Joseph
Bryant, T. J., Kansas City
Buben, Robert W., Hannibal
Buchanan, Barbara N., Kansas City
Buckner, Robert C., Kansas City
Bucy, James G., St. Louis
Budd, John J., Jr., St. Louis
Budke, Harold A., Kansas City
Buehler, Carl T., Jr., Eldon
Buettner, John B., St. Louis
Buhler, Victor B., Kansas City
Buie, Bruce R., Kansas City
Bumgarner, James E., Columbia
Bumgarner, Roger W., Columbia
Bunthrarungroj, Tasanaporn, Kansas City
Bunting, Williston P., Kansas City
Burch, John E., Joplin
Burcham, Tom R., Jr., Farmington
Burde, Ronald M., St. Louis
Burdge, Robert E., St. Louis
Burford, Edwin K., Jr., Cape Girardeau
Burford, Thomas H., St. Louis
Burk, E. K., Kansas City
Burke, Robert J., St. Louis
Burkey, Jordan W., Springfield
Burkhart, Edward F., St. Louis
Burleigh, Bruce W., Joplin
Burmeister, R. William, St. Louis
Burns, Francis J., St. Louis
Burns, Francis R., Hannibal
Burns, Thomas W., Columbia
Burnside, Charles R., Kirkwood
Burr, Donald C., Nashville, Ill. (Member St. Louis Medical Society)
Burrows, Stephen D., St. Louis
Burry, Virgil F., Kansas City
Burst, Donald O., St. Louis
Burstein, Robert, St. Louis
Burton, Dale F.. Hannibal
Busby, William E., Jefferson City
Busch, Anthony K., St. Louis
Busiek, Erwin F., Springfield
Busiek, Paul J., Springfield
Busiek, Urban J., Springfield
Bussmann, Donald W., St. Louis
Bussmann, Donald W., Jr., St. Louis
Butcher, Harvey R., Jr., St. Louis
Butcher, Robert W., Kansas City
Butler, E. F., St. Joseph
Butler, Patrick L., Diamond
Butsch, Richard H., St. Louis
Butt, James H., Columbia
Butterworth, Nelson S., Kansas City
Butts. James D., Rolla
Byer, John A., Columbia
Byland, Benjamin F., Maryville
Byland, Samuel J., Wellsville
Bynum, William R., Columbia
Byrne, John E., St. Louis
Byrne, Paul A., St. Louis
Byrum, Fritz A., Ballwin

C

Cabonce, August L., Florissant
Cabral, Galileu, Florissant
Cabrera, Tomas V., St. Peters
Caciolo, Carlo, St. Louis
Cacioppo, Joseph E., St. Louis
Cadice, John B., Florissant
Caffrey, Raymond J., Kansas City
Cain, Alvin R., Lamar
Cain, Charles F., Caruthersville
Caldwell, Fred, Poplar Bluff
Caldwell, John K., Kansas City
Callaghan, Gerard M., St. Louis
Callahan, Donald E., Jennings
Callahan, Joseph D., St. Louis
Callaway, Guy D., Springfield
Callaway, Guy D., Jr., Springfield
Callen, Kenneth E., Columbia
Callihan, Charles F., West Plains
Callman, George, St. Joseph
Calodney, Martin M., St. Louis
Calovich, Emery R., Kansas City
[*] Calvin, Glen, Union
Camacho, Homero, Kansas City
Camel, H. Marvin, St. Louis
Camp, Richard V., Jr., Poplar Bluff
Campbell, A. J., Sedalia
Campbell, Cecil S., St. Louis
Campbell, Edward D., Cape Girardeau
Campbell, Frederick B., Kansas City
Campbell, James E., Macon
Campbell, James W., Advance
Campbell, John G., Kansas City
Campos, Antonio. St. Louis
Campos, Francisco J., St. Louis
Canaan, Samuel A., Jr., St. Louis
Cancelada, Juan, Farmington
Canent, Ramon V., Jr., Kansas City
Canlas, Arsenio L., St. Louis
Canlas, Emilio M., Poplar Bluff
Cannon, Edward M., St. Louis
Cantor, Harvey E., St. Louis
Canty, Eugene J., St. Charles
Capetti, Alex P., Crane
Capps, Eugene C., Shawnee Mission, Kan. (Member Jackson County Medical Society)
Carder, George A., Kansas City
Carleton, Charles E.. Jr., Farmington
Carlin, Albert L., Stanberry
Carlin, M. Richard, St. Louis
Carls, Garry L., St. Louis
Carlson, Arne E., St. Louis
Carlson, E. C., Poplar Bluff
Carlson, Hjalmar E., Kansas City
Carlson, John S., Kansas City
Carmona, Gilberto V., Arnold
Carmondy, John P., St. Louis
Carnahan, Charles E., Columbia
Carnell, B. M., Camdenton
Carnes, Victor M., Joplin
Carolla, Robert L., Columbia
Carpenter, George T., St. Joseph
Carpenter, James L., St. Charles
Carpenter, Wallace, Rockport
Carr, Archie D., St. Louis
Carr, Phillip W., Springfield
Carranza, Mauro J., Hillsboro (Member St. Louis Medical Society)
Carrera, Mario, St. Louis
Carrier, John A., St. Louis
Carrington, Howard W., Lebanon
Carroll, George A., St. Louis
Carroll, Grayson, St. Louis
Carroll, Percy J., Clayton
Carroll, Thomas W., Lamar
Carron, Joseph F., Arnold
Carron, Oscar A., Perryville
Carson, Richard A., Vista, Calif. (Member St. Louis Medical Society)
Carter, Edwin E., Creve Coeur
Carter, James E., Kansas City
Carter, James R., Neosho
Carter, John F., St. Louis
Caruso, Alfred A., Kansas City
Cary, John M., St. Louis
Case, Mary E. S., St. Louis
Case, William F., Kansas City
Casey, Edwin J., St. Louis
Casey, Eliot, Florissant
Cash, Charles R., Kennett
Cashman, John W., Kansas City
Cason, Elbert H., St. Louis
Cassel, Melvin A., St. Louis
Castasus, Manuel, St. Louis
Castillo, Jose L., Titusville, Fla. (Member Semo County Medical Society)
Castillo, Michael E., Kansas City
Castro, Juan M., Creve Couer
Catalano, J. Denis, Ballwin
Catanzaro, Anthony F., St. Louis
Catanzaro, Francis J., St. Louis
Catanzaro, Rudolph E., St. Louis
Cattaneo, Ernest A., Kansas City
Cavanagh, Denis, St. Louis
Cavaness, Ernest W., Encinitas, Calif. (Member Jackson County Medical Society)
Cayabyab, Pedro C., St. Louis
Cejas, Leandro P., Sikeston
Centner, Paul J., Kansas City
Chadaratana, Phadung, St. Louis
Chakrobortty, Hirendra, St. Louis
Chalkley, Judson I., Columbia
Challener, William A., III, St. Joseph
Challoner, David R., St. Louis
Chambers, James Q., Jr., Kansas City
Chand, Suresh, St. Louis
Chandler, R. Allen, Kansas City
Chandra, Mahesh D., Independence
Chanduwadia, D. J., St. Ann
Chang, Lawrence, St. Louis
Chang, Shih-Chung, Maplewood
Chapel, James L., Columbia
Chaplin, Hugh, Jr., St. Louis
Chapman, Charles L., Columbia
Chapman, David W., Independence
Chapman, Jean A., Cape Girardeau
Charles, Benjamin H., St. Louis
Charles, Francois R., St. Louis
Charnas, Raymond M., St. Louis
Chase, Ned B., Jr., Joplin
Chastain, Charles W., Farmington
Chatkupt, Suthon, Excelsior Springs
Chaudhary, Mohammad A., Kansas City
Chaudhuri, Sudha T., Kansas City
Chaudhuri, Tapan K., Kansas City
Cheek, Charles W., Columbia
Cheek, J. William, Springfield
Chehval, Michael J., St. Louis
Chen, Chung-Kuang, St. Louis
Chernoff, Selbert G., Kansas City
Cherre, Anthony J., St. Louis
Cherre, Charles J., St. Louis
Chesanow, Robert L., St. Louis
Chesney, George W., Joplin
Cheuk, Shu-sum, St. Louis
Chiasson, E. Chaille, Columbia
Chieffi, Margaret, St. Louis
Childs, Donnalea S., Kansas City
Childs, Richard M., Kansas City
Chiles, David R.. Smithville
Chinsky, Murray, St. Ann
Chipongian, Raul A., Florissant
Chishti, M. Ishaq, St. Louis
Cho, Kyu S., St. Louis
Choi, Sae Rong, St. Louis
Chou, Yen Ping, Koch
Choudhuri, Ajit Kumar, St. Louis
Chouinard, Michael P., St. Louis
Chowdhury, Dipak, Independence
Christ, Martin H., St. Joseph
Christianson, Charles S., Tyler, Tex. (Member Ozarks County Medical Society)
Christy, John P., Poplar Bluff
Christy, Raymond A., Springfield
Chua, Steven H. T., Florissant
Chung, Kap Eun, Farmington (Member St. Louis County Medical Society)
Chung, Richard T., Kansas City
Churchill, Stephen W., Kansas City
Chute, W. Deward, Moberly
Ciapciak, Stanley J., St. Louis
Clark, Frank I., III, Joplin
Clark, Irving H., Kansas City
Clark, Kendall A., Jefferson City
Clark, Richard E., St. Louis
Clarke, Michael J., Springfield
Clary, William F., Springfield
Claseman, Wilma W., St. Louis
Clasen, Arthur C., Miami Beach, Fla. (Member Jackson County Medical Society)
Clawson, James W., Springfield
Clayton, Edgar L., Springfield
Cleary, Frank, St. Louis
Clendenin, William W., St. Louis
Clever, Henry W., Jr., St. Charles
Cline, Merle A., Kansas City
Clisham, John F., Hannibal
Clothier, Robert W., Independence
Clough, Charles A., Kansas City
Coates, Thomas A., St. Louis
Cobb, James R., Kansas City
Cobb, Milton L., St. Louis
Cobb, Sanford, Kansas City
Coben, Lawrence A., St. Louis
Coburn, Donald F., Kansas City
Cochran, Donald Q., Columbia
Cochran, Jo R., Cape Girardeau
Cochran, Thomas E., Jr., Springfield
Cochrane, Joseph J., Kansas City
Cockerell, Sanford F., Independence
Codilla, Sostenes G., High Ridge
Coffee, Amos L., Willow Springs
Cofer, T. N., Chillicothe
Coffey, Ralph R., Kansas City
Coffin, Theodore A., Kansas City
Cohen, Edward, St. Louis
Cohen, Frank, St. Ann
Cohen, Harry B., Columbia
Cohen, Harry K., Kansas City
Cohen, Hillard K., St. Ann
Cohen, Robert A., Kansas City
Cohen, Robert S., St. Louis
Cohle, Richard R., Carthage
Cohrs, Clarence C., Moberly
Cokingtin, Leovigildo, Independence
Cokrhame, Jack, Florissant
Colbert, Robert S., Sikeston
Colburn, R. Marshall, Madison, Wis. (Member St. Louis Medical Society)
Cole, Harry O., St. Louis
Cole, William R., Smithton
Coleman, Robert L., Kansas City
Colglazier, Mary C., Kansas City
Coller, Frederick B., Springfield
Collins, Edward J., St. Louis
Collins, Gretchen D., Macon
Collins, Jack R., St. Louis
Collins, John A., St. Louis
Collins, John M., St. Louis
Collins, John W., Kansas City

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Collodi, George A., St. Louis
Colom, George A., Kansas City
Colosi, Nicholas J., Ardmore, Pa. (Member St. Louis Medical Society)
Colwill, Jack M., Columbia
Comas, Manuel R., Manchester
Comeau, Richard A., Dexter
Comens, Phillip, St. Louis
Comens, Ruth C., St. Louis
Comer, J. Russell, New London
Comfort, George D., Mexico
Commerford, John F., St. Charles
Cone, Alfred J., Chesterfield
Cone, William, Steelville
Conn, Robert D., Kansas City
Connelly, Michael W., Frontenac (Member St. Charles-Lincoln County Medical Society)
Connors, John P., St. Louis
Conrad, Adolph H., Jr., Clayton
Conrad, Joseph A., Chillicothe
Conrad, Marshall B., St. Louis
Conrad, Raymond C., Springfield
Cook, James R., Springfield
Cook, Jerry W., Kansas City
Cook, Marvin A., St. Louis
Cook, O. W., Caruthersville
Cook, Thomas B., Richmond
Cooper, Barry R., Kansas City (Member Clay County Medical Society)
Cooper, C. Wesley, Springfield
Cooper, Charles W., Jefferson City
Cooper, Claude W., Thayer
Cooper, Henry T., St. Louis
Cooper, James F., Florissant
Cooper, Maurice E., Columbia
Cooper, R. Lee, Warrensburg
Cooper Robert H. Warrensburg
Cooper, Thomas J., St. Louis
Cooper, Thomas P., St. Louis
Cope, James C., Columbia
Cope, Joseph S., Lexington
Copp, Ralph, St. Louis
Coppinger, Thomas A., Kansas City
Corday, Robert J., St. Louis
Cordonnier, James K., Springfield
Cordonnier, Justin, St. Louis
Coronado, Mario A., St. Louis
Corry, Francis M., Springfield
Cortner, Mary C., Kansas City
Corvalan, Juan C., St. Charles (Member St. Louis Medical Society)
Coscia, Robert L., Springfield
Costa, Dominic V., St. Louis
Costello, Cyril J., St. Louis
Costello, Joseph P., Jr., Brentwood
Costen, William S., St. Louis
Costrino, Joseph A., St. Louis
Cottey, J. H., Mexico
Cotton, Thomas R., Kansas City
Coulson, Forest H., Cape Girardeau
Coulter, James W., Springfield
*Courter, Gary, Lebanon
Courter, Larry P., Jefferson City
Cova, Reno R., Jr., Florissant (Member St. Charles-Lincoln County Medical Society)
Cowan, George A. B., Kansas City
Cowdry, Edmund V., Jr., Creve Coeur
Cox, John P., St. Joseph
Cox, Kenneth E., Kansas City
Cox, Mary E., St. Louis
Cox, Robert D., Florissant
Cox, William A., Jefferson City
Cox, William L., Liberty (Member Jackson County Medical Society)
Coxe, William S., St. Louis
Cozart, Duane E., Chesterfield
Cozean, Charles H., Jr., Cape Girardeau
Craig, Alan G., St. Louis
Craig, Herbert W., Columbia
Craig, Irwin T., Joplin
Craig, Owen W. D., St. Joseph
Craig, Richard O., St. Joseph
Crain, James W., Branson
Crane, John Bruce, Washington
Craven, Thomas F., University City
Crawford, Archie L., Joplin
Crawford, Katherine J., University City
Crawford, Oral B., Springfield
Crawford, Robert M., Sullivan
Crayton, Billy G., Waverly
Creech, Joseph C., Troy
Cremer, William J., Fulton
Crespin, Stephen R., St. Louis
Crespo, Horacio T., Florissant
Crespo, Remedios R., Florissant
Crider, Russell J., St. Charles
Crighton, John C., Springfield
Criscione, James R., St. Louis
Criscione, James S., St. Louis
Crispell, Lawrence S., Joplin
Critchlow, Wm. C., Sikeston
Crocker, Albert M., Kansas City
Crockett, James E., Kansas City
Croom, Dorwyn W., Malden
Cross, Albert D., Trenton
Crossman, Robert W., Webster Groves
Crosthwait, Ed L., Springfield
Crouch, F. Richard, Farmington
Crouch, Thomas T., Kansas City
Coulter, James W., Springfield
Crow, Martin L., Kansas City
Crowe, John T., Cape Girardeau
Crowell, Hugh C., St. Louis
Crowley, Wm. J., Jr., Columbia
Crozier, Franklin A., Richmond
Cruz, Eligio C., St. Louis
Cruz, Sergio G., Jr., Monett
Csaki, Bela, Kansas City
Cubillo, Enrique, St. Louis
Cuento, Oblendo A., High Ridge
Culley, Thomas S., Columbia
Cullum, Albert G. J., Middlesboro, Ky. (Member St. Louis County Medical Society)
Cunningham, Darral D., Springfield
Cunningham, E. J., Jr., St. Louis
Curnow, Richard B., Liberty
Curran, Desmond, Kansas City
Curry, Michael J., St. Charles
Curts, Calvin J., Kansas City
Cutcliff, Daniel J., Kansas City
Cutler, Gordon B., Jr., St. Louis
Cutler, Harold M., St. Louis
Cutler, Harry, St. Louis
Czebrinski, Edward W., St. Louis

D

Daake, John W., St. Louis
Dabbs, Wilbur D., Neosho
Dagartzikas, A. K., Town & Country
Dahm, Charles H., Jr., St. Louis
Daley, Frank R., Hamilton
Dalton, Arthur R., St. Louis
Dalton, Timothy T., Kansas City
Dames, Richard J., St. Louis
Damron, Edward O., Elsberry
Damron, Oscar H., Warrensburg
Danforth, William H., St. Louis
Danielsson, Ernst P., Springfield
Danis, Peter G., St. Louis
Danis, Richard K., St. Louis
Dankner, Arnold, St. Louis
Dann, David S., Kansas City
Darnell, Dale E., Kansas City
Darnell, Thomas F. B., Columbia
Das, Arabinda, Belleville, Ill. (Member St. Louis County Medical Society)
Dash, Udaya N., St. Louis
Datta, Kapal D., St. Louis
Datta, N. K., Bonne Terre
Daughaday, William H., St. Louis
Daum, Harold F., Sedalia
Daum, Wayne J., St. Louis
Daut, Donald W., Mexico
Davault, George K., Richmond
Davidner, Mark L., Kansas City
Davidson, Kendrick C., Leawood, Kan. (Member Jackson County Medical Society)
Davidson, Morris, Clayton
Davis, C. Braxton, Nevada
Davis, Charles S., Joplin
Davis, David, Columbia
Davis, Donald R., Kansas City
Davis, Edgar W., St. Louis
Davis, Gustave L., St. Louis
Davis, Herbert V., Kansas City
Davis, Jack M., Kansas City
Davis, Kenneth A., Kansas City
Davis, Landis Y., Canton
Davis, Leonard L., Jr., Mexico
Davis, Martin W., St. Louis
Davis, Mary A., St. Louis
Davis, Wilbur L., Charleston
Davis, William E., Columbia
Davisson, Walter F., Jefferson City
Day, Maxwell, McAllen, Texas (Member Buchanan County Medical Society)
Deakin, Rogers, St. Louis
Dean, Francis D., Fayette
Debnam, James W., Jr., St. Louis
Decanini, Mario, St. Joseph
Deeken, James H., Kansas City
Deeths, Tony M., St. Louis
De Feo, Theodore C., Kansas City
DeGenova, Gerald H., Ste. Genevieve
Deitchman, Robert B., St. Louis
De Jesus, Alberto, St. Louis
de la Torre, John J., Sullivan
Del Carmen, Jaime J., Maryland Heights
DeLeon, Romualdo V., Arnold
Deles, Vicente D., Crystal City
Deleste, Carlos J., Alhambra, Calif. (Member St. Louis Medical Society)
Deligeorges, John, Kansas City
DeLima, Clarence A., Columbia
Del Pizzo, Ferdinand, St. Charles
Del Rosario, Horacio O., St. Louis
Del Valle, Fernando, St. Louis
DeMaria, Peter F., Kansas City
DeMott, John D., Kansas City
DeMotte, John A., Kansas City
Dempsey, Herbert A., Lee's Summit
Denk, Alan F., St. Louis
Denninghoff, James C., Columbia
Dennis, W. Paul, Flat River
Dennison, Carl F., St. Louis
Dent, George W., Jr., Farmington
Denton, Robert E., Smithville
Dernoncourt, John E., Smithville
Desai, Ravindra, St. Charles
DeTar, Burleigh E., Joplin
Dettmer, Robert F., Ironton
de Ungria, Estelita Maria, St. Louis
de Ungria, Pablo Calma, St. Louis
Deutch, Max, St. Louis
de Vera, Anson E., St. Louis
Devgan, Baldev K., St. Louis
Devgan, Manju, St. Louis
Devine, John B., St. Louis
Devine, Mark W., Jr., Kansas City
Devins, George S., Kansas City
DeVivo, Darryl C., St. Louis
Dew, Thomas A., St. Louis
Dewald, Paul A., St. Louis
Dewein, Edward G., St. Louis
Dexheimer, Frank R., Columbia
Dexter, James D., Columbia
Dickhaus, Donald, Columbia
Dickler, Donald J., St. Louis
Diehr, Maurice A., St. Louis
Diekroeger, Manuel L., Boonville
Deimer, Peter A., St. Louis
Dierker, H. D., Farmington
Diestelhorst, James A., Creve Coeur
Difilippo, Emil A., Bridgeton (Member St. Charles-Lincoln County Medical Society)
DiLeo, Senatro W., Florissant
Dillard, Burl M., St. Louis
Dillard, Erin M., Springfield
Dills, Joseph N., Springfield
Dimond, E. Grey, Kansas City
Dinelli, Frank E., Poplar Bluff
Dinkins, James A., Cape Girardeau
Diveley, Rexford L., Kansas City
Dixon, George D., Kansas City
Dixon, John R., Brookfield
Dixon, Vewiser L., Kansas City
Dlabal, Luke J., Independence
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Dmytryk, Eugene T., St. Louis
Doane, William L., Kansas City
Dodge, Mark, Kansas City
Dodge, Philip R., St. Louis
Doerhoff, Adelia, Jefferson City
Doerhoff, Alan, Jefferson City
Doering, Robert W., Kansas City
Doisy, Philip P., St. Louis
Doisy, Robert A., Glendale
Dolan, C. Terrance, N. Kansas City (Member Clay County Medical Society)
Dolan, Daniel L., Springfield
Dolan, John T., Jr., St. Louis
Domann, Darrel D., Springfield
Domke, Herbert R., Jefferson City (Member Callaway County Medical Society)
Domond, Lherrisson, St. Louis
Donaldson, Robert C., St. Louis
Donati, Robert M., St. Louis
Donegan, Judith H., Columbia
Donegan, William L., Columbia
Donley, Leo F., Jr., St. Louis
Donley, Robert R., Monett
Donnell, Harold E., De Soto
Donnell, Robert H., Crystal City
Donnell, Thomas A., De Soto
Dooley, Joseph M., Jr., St. Louis
Dorsch, Ervin H., Independence
Dorton, Robert K., St. Louis
Doucette, Raymond C., St. Louis
Dowell, George H., St. Louis
Dowell, J. Larry, Pattonsburg
Downey, James W., Kansas City
Downey, Jon Patrick, Cape Girardeau
Doyle, Charles R., St. Louis
Doyle, Matthew J., Kansas City
Drace, Charles C., Jr., St. Louis
Drake, Avery A., Phoenix, Ariz. (Member Mid-Missouri County Medical Society)
Drake, Roy F., Kansas City
Drake, William L., Jr., St. Louis

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* Doctor of Osteopathy.

Draney, Thomas E., Kansas City
Draper, Bernard, Rolla
Dreher, Richard L., Kansas City
Drescher, Emmett B., St. Louis
Drews, Robert C., St. Louis
Drey, Norman W., St. Louis
Dreyer, Carl J., Webster Groves
Dreyer, Philip V., Huntsville
Dreyer, William F., Houston
Drisko, Robert M., Kansas City
Drowns, Bruce V., Kansas City
Drum, Helen M., St. Louis
Dubuque, Theodore J., Jr., St. Louis
Duemler, Robert H., Kirkwood
Duensing, George F., Louisiana
Duer, Mildred C., Kansas City
Duffy, Francis G., St. Louis
Duffy, Oliver F., Trenton
Duggan, John J., Jr., Kirkwood
Dukstein, Walter G., Kansas City
Dulick, Michael, Brentwood
Duling, Gerald J., St. Charles
Dumadag, Virgilio P., Chesterfield
Dumonceaux, Leonard J., St. Charles
DuMont, Clement C., St. Joseph
DuMontier, R. J., O'Fallon
Dunaway, Howard A., Sikeston
Duncan, David, St. Charles
Duncan, Robert D., Springfield
Duncan, Wm. H., Kansas City
Dunham, Robert H., N. Kansas City
Dunleavy, James D., Kansas City
Dunmire, George Q., Kennett
Dunn, Robert E., Little Rock, Ark. (Member St. Louis Medical Society)
Dunshee, Robert E., Maryville
DuPont, Jean-René, Sikeston
Durie, Robert H., Kansas City
Durkin, John W., Jr., St. Louis
Durnell, Monaford D., Lee's Summit
Durr, Jon W., St. Charles (Member St. Louis County Medical Society)
Durst, Henry, Fulton
Dworkin, Saul, St. Louis
Dwyer, Frank X., Kansas City
Dwyer, Hugh L., Shawnee Mission, Kan. (Member Jackson County Medical Society)
Dwyer, Thomas L., Mexico
Dyer, Dallas J., St. Louis
Dyer, Gary A., St. Joseph
DyRagos, Ramon R., Kansas City (Member Clay County Medical Society)
Dzundzev, Penco, St. Louis

E

Eachempati, Rama G., St. Louis
Eachempati, Uma R., Chesterfield
Eades, Dee W., St. Louis
Eades, Joseph W., St. Louis
Eagleton, Mark D., St. Louis
Earnest, James B., Kansas City
Earp, Ralph K., St. Louis
Ebel, Eugene H., Florissant
Eberle, Vincent L., St. Louis
Eck, Birkle, St. Louis
Ecker, Decider, Pacific (Member St. Louis County Medical Society)
Eckert, Clarence T., Sarasota, Fla. (Member St. Louis Medical Society)
Ecklund, Archibald M., San Diego, Calif. (Member St. Louis Medical Society)
Ector, Henry J., Mexico
Edele, Eugene H., St. Louis
Edelman, Alan H., St. Louis
Edison, John M., Springfield
Edmond, Beauvoir H., St. Louis
Edmonds, Robert W., Sedalia
Edwards, D. R., Sedalia
Edwards, Donald E., Cape Girardeau
Edwards, James E., St. Louis
Edwards, Joseph C., St. Louis
Edwards, Theodore F., Kansas City
Edwards, Waldo B., Kirkwood (Member Jefferson County Medical Society)
Efstathianos, Kimon, St. Louis
Egan, Robert C., St. Louis
Egan, Thomas F., St. Louis
Eggers, George W. N., Jr., Columbia
Eggleston, Donald E., Macon
Eggleston, Harry C., St. Louis
Eggleston, Thomas F., St. Louis
Ehrlich, Carl F., Jr., St. Louis
Eidelman, Jack R., St. Louis
Eigel, Edwin G., St. Louis
Eimer, Charles E., St. Louis
Eisemann, Gustave, Kansas City
Eisen, Arthur Z., St. Louis
Eisenmann, Benjamin P., New Haven
Ekern, H. Peter. Mexico
Eklund, Alfred W., Pleasant Hill
Eldenburg, Donald, Sedalia
Elders, Frank A., Jr., Cuba
Elias, David J., Independence
Eliasson, Sven G., St. Louis
Eliscu, Juliette, Joplin
Elkadi, Ahmed, Springfield
Elkins, Ronald F., Springfield
Eller, C. Howe, Santa Fe, N.M. (Member St. Louis County Medical Society)
Eller, Gordon W., St. Joseph
Ellersieck, Dorothy M., St. Louis
Ellett, William H., Appleton City
Ellfeldt, Howard J., Kansas City
Elliott, Raymond G., Kansas City
Elliott, Wade E., Kansas City
Ellis, David, Overland Park, Kan. (Member St. Louis Medical Society)
Ellis, Francis J., Springfield
Ellis, Harry L., Springfield
Ellison, Leroy E., Warren, Ark. (Member St. Louis County Medical Society)
Ellsasser, James C., St. Louis
Ellsworth, Willard, Cainsville
Elrod, Dennis B., Cape Girardeau
Elser, Otto H., Independence
Elson, Julius, St. Louis
El'Toumi, Ahmed A., St. Louis
Emeran, George, St. Louis
Emerson, Reynolds L., St. Louis
Engel, Lawrence P., Shawnee Mission, Kans, (Member Jackson County Medical Society)
Engelhardt, Robert C., Poplar Bluff
Engelmann, Calvin E., Kansas City
Engleman, Reinhold, Kansas City
English, Milton T., Jr., Kirksville
English, Wallace D., Cardwell
Epstein, James M., St. Louis
Ericcson, Samuel E. F., Kansas City
Erickson, H. John, Sedalia
Ernst, Edwin C., Jr., St. Louis
Ernst, Joseph G., St. Louis
Ernst, Richard E., St. Louis
Ernst, Roland P., St. Louis
Escobedo, Bolivar, Manchester
Escoffery, Richard, St. Louis
Eshelman, Albert D., Independence
Esparrago, Francisco R., Jr., Monett
Espinosa, Tomas, Fulton
Esslinger, Arthur T. J., St. Louis
Essmyer, Joseph K., Cape Girardeau
Esterly, James A., Columbia
Estes, Jack M., St. Louis
Esther, John R., Joplin
Estrada, Corazon deLeon, St. Louis
Estrada, Jesus I., St. Louis
Etienne, Robert B., St. Louis
Eto, Jackson, St. Louis
Eubank, David F., Kansas City
Eubank, Dillard M., Raytown
Eubank, William Y., Kansas City
Eugenio, Romeo R., Perryville
Euprasert, Pricha, Kansas City
Evans, Elizabeth A., Kansas City
Evans, Ezra L., Jr., Springfield
Evans, Lawrence G., St. Louis
Evans, Lawrence L., Kansas City
Evens, Ronald G., St. Louis
°Everett, James E., Kansas City
Eversoll, Norton J., Hollywood, Fla. (Member St. Louis County Medical Society)
Exarhou, Klark, Florissant
Exon, C. Stuart, Jefferson City
Eyerman, Edward L., Jr., St. Louis
Eyermann, H. Walter, Warrenton

F

Fabian, Leonard W., St. Louis
Fabito, Daniel C., Maryland Heights
Fabito, Melinda A., Eureka (Member St. Louis County Medical Society)
Fair, William L., Chillicothe
Fairchild, James F., Perryville
Fairchild, Robert C., Shawnee Mission, Kan. (Member Jackson County Medical Society)
Fajatin, Romulo J., St. Charles
Fakhoury, Donald A., Kansas City
Fallon, Richard H., St. Louis
Falter, Richard T., Hutchinson, Kan. (Member Clay County Medical Society)
Farkas, James R., Sedalia
Farley, Claude C., Kansas City
Farmer, Norma D., Farmington
Farney, Jacob P., Kansas City
Farnham, Milo M., Independence
Farnsworth, Jesse J., Kansas City
Farrales. Franklin B., Kansas City
Farrell, Corinne, Columbia
Farrell, Frank W., St. Louis
Farrell, Robert J., St. Louis
Farrell, S. L., Washington
Farthing, Gene W., Springfield
Fathman, Anthony E., St. Louis
Favazza, Armando R., Columbia
Fayez, Jamil A., Kansas City
Fayne, Fred A., Kansas City
Fee, Chester F., Kansas City
Feeley, Donald R., Ballwin
Fehlman, Bernard F., Jr., St. Louis
Feibel, Robert M., St. Louis
Feigin, Ralph D., St. Louis
Feind, Earl E., Rolla
Feist, George V., Kansas City
Feist, Wm. Edgar, Kansas City
Felder, James P., St. Charles
Feldman, David, Creve Coeur
Felix, Robert H., St. Louis
Feller, Harold H., St. Louis
Fellhauer, Carl M., St. Louis
Fellows, Richard A., Kansas City
Felts, James A., St. Louis
Feltz, Lawrence W., Perryville
Ferguson, Donald S., Kansas City
Ferguson, John L., Springfield
Ferguson, John P., Jr., Springfield
Ferguson, L. H., Jr., Alexandria, La. (Member Jasper County Medical Society)
Ferguson, Luther J., St. Joseph
Ferguson, Ralph L., Joplin
Ferguson, Robert M., Joplin
Ferguson, Thomas B., St. Louis
Ferneau, James E., Columbia
Ferrara, John P., Chesterfield
Ferreira, Afonso C., Belleville, Mich. (Member St. Louis County Medical Society)
Ferrell, Thomas E., Jr., Springfield
Ferrendelli, James A., St. Louis
Ferris, Carl R., Kansas City
Ferro, Anthony L., St. Louis
Ferry, Richard J., St. Louis
Fetick, Paul G., St. Louis
Figueroa, Eliseo O., St. Louis
Files, James B., Jefferson City
Finger, Donald H., St. Louis
Fingerhood, Marvin G., St. Louis
Fingert, Hyman H., St. Louis
Fink, LeRoy L., Florissant
Fink, Roger L., Springfield
Finkel, Barney W., St. Louis
Finkle, Robert H., Independence
Finn, Murray E., St. Louis
Finnegan, Joseph V., St. Louis
Fiordelisi, Rocco J., St. Louis
Fischer, Charles K., Richton Park, Ill. (Member St. Louis Medical Society)
Fischer, Edward H., Kansas City
Fischer, Erich, St. Louis
Fischer, John R., Clayton
Fischer, Jose, Shawnee Mission, Kan. (Member Jackson County Medical Society)
Fischer, Martin J., St. Joseph
Fischer, Theodore, Altenburg
Fish, Richard., St. Louis
Fish, Virgil O., St. Louis
Fisher, James K., Overland Park, Kan. (Member Jackson County Medical Society)
Fisher, Joseph L., St. Joseph
Fisher, Stanley D., Sedalia
Fishman, John J., St. Louis
Fishman, Marvin A., St. Louis
Fitch, C. H. Max, Springfield
Fitch, Coy D., St. Louis
FitzGerald, Leo P., St. Louis
Fitzgerald, Robert H., Kansas City
Fitzgerald, William T., St. Louis
FitzSimmons, James G., Kansas City
Fivian, Gerald J., St. Louis
Flance, Israel J., St. Louis
Flanders, Virgil E., Leawood, Kan. (Member Clay County Medical Society)
Flanigan, George D., Jr., St. Louis
Flatley, John A., Kansas City
Flavan, David B., St. Louis
Fleishman, Alfred, St. Louis
Fleming, Allan R., Kansas City
Fleming, J. Will, Moberly
Fleming, Robert J., St. Charles
Fleming, Thomas S., Moberly
Fletes. James W., St. Louis
Floerchinger, James S., St. Charles
Florendo, Federico N., Jr., Hannibal
Florendo, Purificacion T., Hannibal
Flores-Vega, Carlos H., St. Louis
Floro, Mariano N., Florissant
Flotte, Bernard H., Florissant
Flotte, Sylvester A., Florissant
Flynn, Edward P., St. Louis
Flynn, James M., Kansas City
Flynn, John T., St. Louis
Flynn, Joseph E., St. Louis
Flynn, Thomas T., St. Louis
Fogarty, William M., Jr., St. Louis
Fogerson, Virginia L., Springfield

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Fogle, Philip R., Springfield
Folck, William P., Kansas City
Folkner, A. L., Warrensburg
Foote, Jerry E., Columbia
Ford, Lee T., Jr., Belleville, Ill. (Member St. Louis Medical Society)
Ford, Thomas E., St. Louis
Ford, William, Farmington
Foreman, Phillip B., Hannibal
Forgrave, Leon P., St. Joseph
Forman, George W., St. Joseph
Forman, Louis H., Kansas City
Forsen, James A., Gower (Member St. Louis Medical Society)
Forsman, Waldo W., Jr., St. Louis
Forsyth, B. Todd, St. Louis
Forsythe, Lees C., Kansas City
Forsythe, Robert W., Kansas City
Forti, John J., St. Louis
Fortin, Felix D., III., Kansas City
Foster, C. Stephen, St. Louis
Fotopoulos, Chris K., North Kansas City
Fouts, Dallas B., Sr., Independence
Fowler, Fred D., Kansas City
Fowler, I. Charles, N. Kansas City
Fowler, James W., Kansas City
Fowler, Marvin L., West Plains
Fox, Gerald E., St. Joseph
Fox, Leon J., St. Louis
Fox, Robert E., St. Louis
Francis, William C., Springfield
Francisco, Clarence B., Kansas City
Francisco, Dominic, St. Louis
Francisco, Edgardo C., Nevada
Franco, Pilar Juan, Kansas City
Frank, Alvin R., St. Louis
Frank, Gael R., Kansas City
Franklin, Curtis U., Kansas City
Franklin, Harold A., St. Louis
Franklin, Max S., St. Louis
Fraser, Daniel M., St. Louis
Fraser, Richard A., Poplar Bluff
Frawley, Thomas F., St. Louis
Frazier, Robert E., Columbia
Frazier, Robert L., Charleston
Frazier, William L., St. Louis
Frederick, Raymond O., St. Louis
Freedman, Harold, St. Louis
Freedman, Ruth S., St. Louis
Freeman, David M., St. Louis
Freeman, Jerry C., Kansas City
Freeman, Spencer L., Kirksville
Freiheit, Harold J., St. Louis
Freiman, S. Michael, St. Louis
Freimuth, L. E., St. Louis
Frein, Donald E., Harrisonville
Freund, Samuel J., St. Louis
Fried, Frederick E., Columbia
Friedman, Bernard, St. Louis
Friedman, Ira J., St. Louis
Friedman, Morris L., Kansas City
Friedman, Paul L., St. Louis
Friedman, Robert H., St. Louis
Friedrich, Anthony P., St. Louis
Friedrich, Ernst R., St. Louis
Fries, Armand D., St. Louis
Fries, John W., St. Louis
Friskel, Arthur K., St. Louis
Fristoe, Frank Jr., Columbia
Fritsch, Andrew J., Joplin
Fritzlen, Thomas J., Kansas City
Froelich, Edwin J., Lebanon (Member St. Louis County Medical Society)
Froelich, R. W., Lebanon
Frueh, Bartley R., Columbia
Frumson, Guy H., St. Louis
Fryer, Minot P., St. Louis
Fuchs, George J., Barnett
Fuchs, George J., Jr., Columbia
Fuhrman, Donald L., Kansas City
Fujita, Milton T., St. Louis
Fuleihan, Farid, St. Louis
Fulks, Richard B., California
Fullgrabe, Emil A., Jefferson City
Funsch, Robert E., St. Louis
Furla, Gus J., St. Louis
Furlow, Leonard T., Crystal River, Fla. (Member St. Louis Medical Society)
Fury, Tex E., Salina, Kan. (Member Jackson County Medical Society)
Fuson, Levi H., St. Joseph
Fuson, William A., Trenton

G

Gabilondo, Jorge, Augusta, Ga. (Member St. Louis Medical Society)
Gaffney, Caldwell J., St. Louis
Gafney, George T., St. Louis
Gagliardo, Joseph, St. Louis
Gaines, Albert, Kansas City
Gaines, Quentin M., Kirkwood
Gainey, Harold L., Kansas City
Gaitonde, Mangesh R., Kansas City
Galakatos, Andrew F., St. Louis
Galbol, Harley, Excelsior Springs
Galbreath, Ashford M., Kansas City
Gale, Arthur H., Overland
Gale, Joseph F., Chillicothe
Gale, Philip R., St. Louis
Galeota, William R., Columbia
Galinsky, Leon J., Green Valley, Ariz. (Member Ozarks County Medical Society)
Gall, Ira, St. Louis
Gallagher, Lionel M., California
Gallagher, Neil I., St. Louis
Galvez, Sisenande P., Jr., Marceline
Gambill, Alice F., Columbia
Gammel, George E., Columbia
Gandlmayr, Jack M., St. Louis
Gansloser, Wilbert M., Clayton
Gantner, George E., Jr., St. Louis
Gantz, John A., St. Louis
Gapasin, Ernesto, Lebanon
Garcia, Charles L., Mexico
Garcia, Francisco, St. Louis
Garcia-Ferrer, Eduardo, St. Louis
Gard, Raymond F., Sun City, Ariz. (Member Jackson County Medical Society)
Gardner, Joseph A., Joplin
Gardner, Joseph W., Kimberling City
Garfinkel, Bernard T., St. Louis
Garner, James H., Kansas City
Garner, Lynn M., Jefferson City
Garner, Royal S., Jefferson City
Garrett, Glen H., Columbia
Garrison, David L., St. Joseph
Garrison, Norman A., Jr., Corinth, Miss. (Member Dunklin County Medical Society)
Garrison, Roy F., Kansas City
Garrison, T. W., Seoul, Korea (Member Mid-Missouri County Medical Society)
Garotto, Lewis J., Columbia
Gary, George, Marceline
Gaska, Walter J., Springfield
Gaskins, John H., Kansas City
Gass, Michael, New Orelans, La. (Member St. Louis Medical Society)
Gaston, Samuel Lee, Joplin
Gauer, Robert J., Kansas City
Gaunt, Frank P., Webster Groves
Gaunt, William D., Columbia
Gauthier, Charles P., Kansas City
Gay, Elizabeth K., Florissant
Gearhart, David L., St. Louis
Gearhart, Merriam, Bethany
Gearhart, Wilbur H., St. Louis
Gedney, William B., Valley Park
Geha, Alexander S., St. Louis
Geha, Braham J., Kansas City
Geiger, William A., Jr., Kansas City
Geise, August W., Jr., St. Louis
Geisse, Guillermo, St. Louis
Gellman, Elliott F., St. Louis
Gempel, Paul A., Shawnee Mission, Kan. (Member Jackson County Medical Society)
Gentry, Enoch N., Jr., Kansas City
Gentry, Marvin C., Ava
Gentry, Merritt L., Springfield (Member Cole County Medical Society)
Gentry, Michael A., Springfield
Gentsch, Kenneth W., Glendale
George, Theodore, Marceline
Gerdes, John A., Springfield
German, Walter A., Jr., Springfield
Germann, Donald R., Kansas City
Germuth, Frederick G., Jr., St. Louis
Gernstetter, Sangwill L., Poplar Bluff
Gerowin, Lance, St. Louis
Gerst, Aloysius C., Florissant
Giannellis, C., St. Louis
Gibson, David M., Kansas City
Gibstine, Marvin H., St. Ann
Giddings, Frank C., Springfield
Gideon, Charles, St. Louis
Gieselman, Ralph V., St. Louis
Giesler, Donald H., Osceola
°Giffen, L. E., Jefferson City
Giffin, James M., Springfield
Gifford, Christopher G., Shawnee Mission, Kan. (Member Semo County Medical Society)
Gilani, Abdollah, N. Kansas City (Member Clay County Medical Society)
Gildea, Edwin F., St. Louis
Gildea, Margaret C. L., St. Louis
Gilden, Jerome J., St. Louis
°Gilgore, Alfred, Lenexa, Kan. (Member Jackson County Medical Society)
Gill, Paul J., Springfield
Gillespie, William J., Idaho Falls, Idaho (Member St. Louis Medical Society)
Gilliland, Charles E., Cameron
Gillispie, Roy, Branson
Gilpin, Doris C., St. Louis
Gilula, Louis A., Ladue
Ginardi, Donald E., Kansas City
Ginsberg, Norman A., Kansas City
Giraparnont, Bang Orn, Clayton
Giraparnont, Prabhak, St. Louis
Gish, Rutledge, Fulton
Gist, William W., Kansas City
Givler, Robert L., Kansas City
Gladney, John H., St. Louis
Glaser, Larry F., Kansas City
Glass, Robert L., Sedalia
Glass, William J., Jr., Monett
Glasscock, Ernest L., Prairie Village, Kan. (Member Jackson County Medical Society)
Glazer, Melvin L., Kansas City
Glover, Jack F., Springfield
Glover, Kenneth, Mt. Vernon
Gnade, Albert J., St. Louis
Godinez, Marye H., St. Louis
Godshalk, M. Fredrica, Columbia
Goebel, Joan M., St. Louis
Goell, Robert S., St. Louis
Goerz, Ann F., Independence
Goerz, Royal D., Independence
Goheen, John R., Kansas City
Gohil, Jivanlal P., Columbia
Goldberg, Isadore E., Braymer
Goldenberg, Jeffrey F., Bronx, N. Y. (Member St. Louis Medical Society)
Goldenson, Max J., St. Louis
Goldfarb, Alvin, St. Louis
Goldgaber, Alberto, St. Louis
Goldkamp, John D., St. Charles
Goldman, Arnold M., St. Louis
Goldman, Gordon M., St. Louis
Goldman, Hyman J., St. Louis
Goldman, Melvin L., St., Louis
Goldman, Stanley L., Kansas City
Goldring, David, St. Louis
Goldring, Sidney, St. Louis
Goldsich, Edward, Kansas City
Goldstein, Marcy A., St. Louis
Goldstein, Marvin F., Kansas City
Gollub, Samuel W., St. Louis
Gomez, Cesar A., Jr., St. Louis
Gonzalez, M. Garza, Warrensburg
Goodman, J. N., St. Louis
Goodman, Nathaniel, St. Louis
Goodrich, Harold A., Webster Groves
Goodson, Wm. H., Jr., Kansas City
Goodwin, Donald W., St. Louis
Goolsbee, Robert L., Kansas City
Gordon, Bruce J., Columbia
Gordon, James M., St. Louis
Gordon, James S., Jefferson City
Gordon, Morris P., Kansas City
Gore, Glenn L., St. Charles
Gorelick, David F., Springfield
Gorla, Wayne O., St. Louis
Gose, Don F., Springfield
Gottsch, Joseph C., Kansas City
Gowdamarajan, Rengasamy, Kansas City
Gowler, Douglas R., St. Louis
Grabau, Gene H., St. Louis
Grable, James D., Portageville
Grabske, Charles F., Independence
Grady, Ronald K., St. Louis
Graff, Ralph J., St. Louis
Graham, Patrick G., Kansas City
Graham, Wallace H., Kansas City
Graneto, Joseph A., St. Louis
Grannemann, Harry N., Rolla
Grant, Claude S., St. Joseph
Grant, John M., St. Louis
Grant, Neville, St. Louis
Grant, Samuel B., St. Louis
Graul, Walter P., St. Louis
Graves, Arthur J., Mt. Vernon
Gray, Mary Louise, St. Louis
Gray, Walter C., Bridgeton
Grebel, Clement B., St. Louis
Green, J. Richard, Independence
Green, Manuel E., Miami Beach, Fla. (Member St. Louis County Medical Society)
Green, Morton R., Belleville, Ill. (Member St. Louis Medical Society)
Green, William R., St. Louis
Greenberg, Charles, Los Angeles, Calif. (Member Buchanan County Medical Society)
Greene, Harry L., Hannibal
Greene, W. Wallace, Kansas City
Greenlund, Nelson, Nevada
Greenman, Marshall B., St. Louis
Gregory, John G., St. Louis
Gresick, Robert J., St. Louis

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riege, Charles W., Florissant
riffin, Donald R., Shawnee Mission, Kan. (Member Jackson County Medical Society)
riffin, Evelyn, Buffalo
riffin, Olin A., Jr., Buffalo
riffin, William T., Columbia
riffith, John A., Jr., Kansas City
riggs, James Y., St. Louis
rim, Edward M., Joplin
rim, George B., Phoenix, Ariz. (Member Franklin-Gasconade-Warren County Medical Society)
rimes, Manning E., St. Joseph
rindon, Joseph B., St. Louis
rinstein, Alberto, Ypsilanti, Mich. (Member Buchanan County Medical Society)
roce, George, Fulton
ronau, Axel R., Koch
rossman, Joel S., Kansas City
rossman, Marvin, Fredericktown
rove, Culp W., Knob Noster
rowdon, John A., Kansas City
rubb, Paul H., Joplin
rubb, Robert L., St. Louis
ruenfeld, Cerhard E., St. Louis
rundmann, William H., St. Louis
runt, Jerome A., Kansas City
uastello, Mario J., Kansas City
ubin, Alan S., Caruthersville
uhleman, Henry V., Jr., Jefferson City
uillen, Rodolfo, St. Louis
uldner, Edmond, Lamar
ulick, Charles R., St. Louis
ullett, Charles C., Kansas City
ummels, Belmont B., St. Louis
undle, Sigmund, Kansas City
unn, Jack, Versailles
unn, Richard W., Kansas City
unn, Walter T., St. Louis
unter, Joe S., St. Joseph
upta, B. S. N., Kansas City
upta, Jitendra K., St. Louis
upta, Narayan C., St. Louis
urnee, Landon H., Jefferson City
ursahani, Man Mohan, St. Louis
ustafson, Jon E., Independence
uze, Samuel B., St. Louis
win, Edward, Springfield

H

Haas, Harry D., Kansas City
Habib, Henry N., Kansas City
Haddock, James N., Webster Croves
Haen, Charles J., Springfield
Haffner, Heinz, St. Louis
Hagan, Daniel J., St. Louis
Hagar, David L., Kansas City
Hagebusch, Omer E., St. Louis
Hagemann, Paul O., Clayton
Hagen, Duane, St. Louis
Hahn, Frederick W., Jr., Kansas City
Haight, John M., Kansas City
Haith, Edward E., Kansas City
Haith, Walter F., Kansas City
Haley, Ted M., N. Kansas City (Member Clay County Medical Society)
Hall, C. Robert, Versailles
Hall, David G., Columbia
Hall, David W., Rogersville (Member Greene County Medical Society)
Hall, Durward C., Springfield
Hall, Eugene W., Ferguson
Hall, Lee A., Clayton
Hall, Marvin F., Joplin
Hall, Preston C., St. Louis
Hall, Ralph R., Kansas City
Hall, Robert A., St. Louis
Hall, Robert T., Kansas City
Hall, Stanley G., Hannibal
Hall, Thomas B., Shawnee Mission, Kan. (Member Jackson County Medical Society)
Hall, William K., St. Charles
Hallaba, M. A. S., Joplin
Hallazgo, Santiago Y., Chesterfield
Halley, Robert H., Florissant
Hallinger, Earl S., Jr., St. Louis
Halloran, Mark J., St. Louis
Halperin, Phillip H., Kansas City
Hamburg, Frederic L., Springfield
Hamill, Robert W., Kansas City
Hamilton, Caldwell K., Creve Coeur
Hamilton, Eugene G., Clayton
Hamilton, Eugene H., Joplin
Hamilton, Thomas R., Duluth, Minn. (Member St. Louis Medical Society)
Hamilton, William P., Aurora
Hamilton, Wm. P., St. Louis
Hamlin, Howard H., Kansas City
Hamlin, Wyeth, Hannibal
Hammes, Roman E., St. Charles
Hammler, Christiana V., St. James
Hammond, David T., St. Louis
Hampton, Henry E., St. Louis
Hampton, Oscar P., Jr., St. Louis
Hampton, Stanley F., St. Louis
Hanan, Ernest B., Springfield
Hanaway, Joseph, St. Louis
Handler, Eric, St. Joseph
Handler, Fred P., Jefferson City
Hanes, Lilly Ann, St. Louis
Hankin, Norman M., St. Louis
Hanna, Fayez, Bridgeton
Hanna, Hugh A., Warrensburg
Hansbrough, Eugene T., Poplar Bluff
Hansel, French K., St. Louis
Hansen, Arthur L., Butler
Hanser, Theodore H., St. Louis
Hanson, Karl H., Jr., Kansas City
Hanss, Armand W., Springfield
Hantman, Stephen L., Florissant
Hantz, Oscar, Florissant
Hardacre, Ruth A., Kansas City
Hardin, William B., Jr., St. Louis
Hardwicke, Henry M., Ashland
Hardy, David A., St. Louis
Hardy, Guerdan, Clayton
Hardy, Henry M., Kansas City
Hardy, John W., Kansas City
Hardy, Patrick J., Florissant
Hardy, Stanton L., Desloge
Harell, Alex, St. Louis
Harford, Carl G., St. Louis
Harkins, William B., St. Louis
Harkness, Harry, Winston-Salem, N. C. (Member Johnson County Medical Society)
Harland, Robert E., La Jolla, Calif. (Member Mineral Area County Medical Society)
Harless, Morris S., Kansas City
Harlow, Lloyd M., Kansas City
Harmon, Ben C., Springfield
Harms, Florian L., Salisbury
Harms, James F., Nevada
Harner, Casper G., St. Joseph
Harper, Fleming B., St. Louis
Harr, Patrick B., Maryville
Harrell, Henry J., Summerfield, Fla. (Member Dallas-Hickory-Polk-Dade County Medical Society)
Harrin, William R., Kansas City
Harris, Hugh S., Jr., Columbia
Harris Lanny W., Kansas City
Harris, Robert J., Columbia
Harrison, Lee B., St. Louis
Harrison, Richard L., Crestwood
Harrison, Stratton W., Springfield
Harrison, Winston E., Columbia
Hart, L. Wayne, Kansas City
Hart, William M., Columbia
Harting, Hugh R., St. Louis
Hartman, B. K., St. Louis
Hartman, Paul T., St. Louis
Hartnett, Thomas D., St. Louis
Hartstein, Jack, St. Louis
Hartwig, Frederick H., Kansas City
Hartwig, John A., St. Louis
Hartwig, Raymond W., Shawnee Mission, Kan. (Member Jackson County Medical Society)
Harvey, Harold D., Springfield
Harwell, J. Larry, St. Louis
Harwell, J. Lester, Lubbock, Tex. (Member Butler-Wayne-Ripley County Medical Society)
Hasek, James A., Mountain Grove
Hasek, O. Martin, Mountain Grove
Hasenmueller, James J., St. Louis
Hata, Daikichi, Boonville
Hatfalvi, Bela I., St. Louis
Haun, Ronald, St. Louis
Hauser, Robert J., Jefferson City
Hausheer, Herman J., Independence
Haw, Marvin T., Jr., Columbia
Hawk, Bray O., St. Louis
Hawker, William D., St. Louis
Hawkins, Doris, Kansas City
Hawkins, George L., Jr., St. Louis
Hawkins, James C., Columbia
Hayden, M. R., Camdenton (Member Mid-Mo County Medical Society)
Hayek, Wesley E., Florissant
Hayes, Lawrence L., Kansas City
Hayes, Paul W., St. Joseph
Haynes, James W., St. Louis
Haynes, Solon E., Kansas City
Haynie, William W., Butler
Hazen, Robert M., Kansas City
H'Doubler, Charles E., Springfield
H'Doubler, Francis T., Jr., Springfield
H'Doubler, Peter B., Springfield
Headrick, John A., Florissant
Hecker, Joseph E., Poplar Bluff
Hedges, Richard C., Excelsior Springs
Heeb, Max A., Sikeston
Heideman, Milo L., St. Louis
Heilbrunn, Ilse, Rolla
Heilman, Edward J., Kansas City
Heiman, Avivi, St. Louis
Heimburger, Elizabeth M., Columbia
Heimburger, Richard A., Columbia
Heins, James N., St. Louis
Helbing, Edward J., Rio Rancho Estates, N. M. (Member St. Louis County Medical Society)
Hellerstein, Stanley, Kansas City
Hellman, Richard, Kansas City
Hellweg, Charles E., Mt. Vernon
Hellweg, Raymond W., Florissant
Helman, Richard G., Kansas City
Henares-Levy, L., St. Louis
Henderlite, John W., St. Louis
Henderson, T. W., Dexter
Hendin, Aaron, Olivette
Hendren, Thomas H., N. Kansas City (Member Clay County Medical Society)
Hennelly, John J., St. Louis
Henry, Clarke Latta, Kansas City
Henry, Lawrence D., Columbia
Henry, Robert D., Harrisonville
Henschel, Eugene V., St. Louis
Henzel, John H., Columbia
Her, Kyu Sook, St. Louis
Herbert, Charles T., Cape Girardeau
Herdoiza, Alfonso W., Kansas City
Herfkens, Kenneth D., Springfield
Herjanic, Marijan, St. Louis
Herman, Allen I., St. Joseph
Herman, Edwin M., Kansas City
Herman, Morris, St. Louis
Hernandez, Salvadore, St. Louis
Herrman, George V., Sunrise Beach (Member Jackson County Medical Society)
Hershey, Falls B., St. Louis
Hertel, Ronald C., St. Louis
Hervey, Wm. H., II, Kansas City
Heryer, John W., Kansas City
Herzen, Alexander T., St. Louis
Herzog, Godofredo M., Florissant
Hesker, Albert E., St. Louis
Hetlage, Louis P., Troy
Heusler, Anton F., St. Louis
Heutel, Lee B., St. Louis
Hiatt, Barry A., St. Louis
Hibbard, Blaine Z., Kansas City
Hickcox, John P., Columbia
Hickerson, William H., Independence
Hickey, Glenn M., Manchester
Hickey, James L., St. Louis
Hicks, Robert S., St. Louis
Higgins, Philip C., St. Louis
Hightower, Harry G., St. Louis
Hilbert, Paul H., St. Louis
Hildreth, H. Rommel, St. Louis
Hilgers, Thomas W., St. Louis
Hill, George J., St. Louis
Hill, Jack H., Kansas City
Hill, James E., Fulton
Hill, Ronald T., Dexter
Hill. XaCadene A., St. Louis
Hilliard, Alphonso W., St. Louis
Hillman, Richard E., St. Louis
Hills, Joseph E., Springfield
Hilton, Paul E., Joplin
Hinds, Paul A., Springfield
Hinds, R. David, Hannibal
Hink, Frederick W., Independence
Hironimus, John, St. Louis
Hirsch, Joe E., Kansas City
Hirsch, John D., St. Louis
Hite, Dennis E., Lebanon
Ho, Grinny H. C., Sikeston
Hoadley, William D., Kansas City
Hobbs, Ceorge H., Warrensburg
Hobbs, John E., St. Louis
Hobson, Gerald, St. Louis
Hoctor, Emmett F., Farmington
Hodge, Robert H., Kansas City (Member Clay County Medical Society)
Hodgson, Frank H., Kansas City
Hoech, George P., Jr., Kansas City
Hoelscher, Harold F., Warrenton
Hoeper, Samuel D., Grandview
Hoeper, Sam D., Jr., Grandview
Hoffman, Jacob S., Kansas City
Hoffmann, Alan L., Kansas City
Hoffmann, Augustin D., St. Louis
Hoffmann, Ronald E., St. Louis
Hofling, Charles K., St. Louis
Hofmeister, Roger W., Columbia
Hofstatter, Leopold, St. Louis
Hogan, Cornelius E., St. Louis
Hogan, Daniel F., Brownsville, Texas (Member Jackson County Medical Society)

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Hogan, John R., St. Louis
Hogan, Patrick A., St. Louis
Hogan, Patrick C., St. Louis
Hogancamp, Glenn E., Ellisville
Hoja, W. Alexander, Poplar Bluff
Holbrook, Charles K., St. Louis
Holcomb, John K., Cape Girardeau
Holder, Thomas M., Kansas City
Holemon, R. Eugene, St. Louis
Holland, Robert D., Springfield
Holley, Donald B., Camdenton
Hollinger, Lloyd A., Kansas City
Hollingsworth, Ray S., Clinton
Hollis, Richard W., Springfield
Hollo, Vencel W., St. Louis
Hollocher, Richard J., Creve Coeur
Hollweg, Kenneth C., Kansas City
Holman, Joseph G., Kansas City
Holmes, Daniel E., Springfield
Holmes, David R., Springfield
Holscher, Edward C., St. Louis
Holt, Earl P., Jr., St. Louis
Holt, Waldo S., Kansas City
Holt, William E., St. Louis
Holtmann, Barbel, St. Louis
Holton, Edward B., Independence
Holtz, Alan S., Kirkwood
Holtz, Sumner, St. Louis
Holtzman, Samuel, Chicago, Ill. (Member Jasper County Medical Society)
Hook, Waller G., Shawnee Mission, Kan. (Member Jackson County Medical Society)
Hookerman, Bruce J., St. Ann
Hoover, Bernard L., St. Louis
Hoover, H. Lee, Jr., Springfield
Hopkins, Florian G., Gideon
Hopkins, James P., Kansas City
Hopkins, Thomas J., Sedalia
Hopkins, T. Spencer, Sedalia
Horenstein, Simon, St. Louis
Hori, Jose M., Moberly (Member Boone County Medical Society)
Horn, Paul C., Cape Girardeau
Horner, John L., St. Louis
Hornstra, Robijn K., Kansas City
Horrilleno, Emilio G., St. Louis
Horton, James D., Springfield
Horwitz, Irwin B., St. Louis
Houck, Russell M., Kecoughtan, Va. (Member Clay County Medical Society)
Houston, Vincent T., St. Louis
Hovadhanakul, Praphat, St. Louis
Howden, Thomas L., St. Joseph
Howe, Albert L., St. Louis
Howe, Louis F., St. Louis
Howell, Billy D., Brookfield
Hoxworth, Gerald M., Mexico
Hoye, Robert C., Farmington
Huang, Chuong Chun, St. Louis
Huang, Jun-Shen, Kennett
Hubbard, Sally L., Springfield
Hubbell, Ira G., Columbia
Huber, Lasley E., Moberly
Huck, Frank F., Fenton
Huck, Richard F., St. Louis
Huckstep, Robert A., Farmington
Hudgens, Richard W., St. Louis
Hudson, G. R., Moberly
Huewe, Douglas A., Springfield
Huffman, Thomas L., Butler
Huggins, Albert M., St. Louis
Hughes, Charles P., St. Louis
Hughes, Judson M., St. Joseph
Hughes, Michael F., Kansas City
Hughes, Robert G., St. Louis
Hughes, Shelby B., Clinton
Hulbert, Bernard, St. Louis
Hulstra, Johannes F. W., Springfield
Hummel, Anton J., St. Louis
Hummel, William C., St. Louis
Humphrey, James, Mound City
Humphreys, Edward T., Boonville
Hungate, Carroll P., Kansas City
Hunkeler, John D., Kansas City
Hunleth, Frank E., St. Louis
Hunt, John L., Poplar Bluff
Hunt, John W., Jr., Farmington
Hunt, Robert S., Cape Girardeau
Hunt, Thomas R., Kansas City
Hunter, Martin P., Kansas City
Huntington, Ione, Mt. Vernon
Hunzicker, Warren J., Kansas City
Huq, Md. Nasrul, Mexico
Hurst, Wilfred W., Joplin
Husain, Syed A., Columbia
Huse, William J., II., Kansas City
Hutchinson, James H., Jr., St. Louis
Hutchinson, William B., St. Louis
Hutto, A. Herman, St. Louis
Hwang, Kim Won, St. Louis
Hwang, Yung H., Carthage (Member Boone County Medical Society)
Hyatt, Robert W., Los Angeles, Calif.
Hyde, Lawrence L., Kansas City
Hyman, Anna, St. Louis

I

Ide, Carl H., Columbia
Ide, Lucien W., St. Joseph
Idewu, Olawale O., St. Louis
Imes, Elvin D., Maryville
Ingham, Walton C., Kansas City
Inkley, John J., St. Louis
Inman, Max M., St. Louis
Ippensen, John H., Springfield
Irick, Carl C., N. Fort Myers, Fla. (Member St. Louis County Medical Society)
Irvin, William M., St. Louis
Irvine, John W., Kansas City
Irwig, Fred, Kansas City
Isaac, Anita M., Springfield
Isbell, Charles H., Carthage
Ise, Frank H., N. Kansas City (Member Clay County Medical Society)
Ishida, Yasuo, St. Louis
Islam, Mohammed N., St. Louis
Ittner, George W., Jr., St. Louis
Ivy, Henry B., Springfield
Izmirlian, Grant, St. Louis

J

Jablonski, Raymond C., St. Charles (Member St. Louis Medical Society)
Jackson, Edward K., Clarksville
Jackson, Haywood R., Kansas City
Jackson, Robert L., Columbia
Jackson, Vernon B., Fulton
Jacob, Karl A., Jr., St. Louis
Jacob, Walter P., Kansas City
Jacobs, Charles C., St. Louis
Jacobs, Frederick A., St. Louis
Jacobs, Morton, Kansas City
Jacobs, Walter H., Kansas City
Jaeckle, Richard G., St. Louis
Jaeger, Joseph N., Jackson
Jaffe, Bernard M., St. Louis
Jain, Savitri, St. Louis
James, Elizabeth J. P., Columbia
James, Otis E., Jr., Kansas City
James, Ronald C., Columbia
Jameson, James E., Springfield
Janes, Donald R., Kansas City
Janney, James G., Jr., St. Louis
Jansen, Robert, Kansas City
Jarosewycz, Demetrius, St. Louis
Jarvis, Cathy C., Ballwin
Jatala, Tjaz A., St. Louis
Jaudon, Joseph C., St. Louis
Jayanandaiah, H. P., Hannibal
Jean, J. Ted, St. Louis
Jeans, Virgil, Joplin
Jenab, Morteza, Kansas City
Jennett, James H., Kansas City
Jensen, Joshua E., Florissant
Jick, Sidney, St. Louis
Jimenez, Jose, St. Joseph
Jobe, Charles L., Jr., Springfield
Joffe, William S., St. Louis
Joftus, Morris, St. Louis
Johnsgard, Larry S., Columbia
Johnson, C. Laurence, Kansas City
Johnson, Charles Julius, St. Louis
Johnson, Charles S., Warrensburg
Johnson, Dallas A., Kansas City
Johnson, Earl W., Cape Girardeau
Johnson, Ernest D., Cape Girardeau
Johnson, Fritz M., Springfield
Johnson, Gareth R. P., Kansas City
Johnson, George A., Springfield
Johnson, George L., Springfield
Johnson, James S., Kansas City
Johnson, Joseph C., Jr., Springfield
Johnson, Joseph E., Kansas City
Johnson, Mitchell D., Ferguson
Johnson, Richard E., Columbia
Johnson, Richard L., Kansas City
Johnson, Roy, Foristell (Member St. Louis County Medical Society)
Johnson, Thomas M., Kansas City
Johnson, Warford B., Springfield
Johnson, William F., Springfield
Johnston, Glen P., St. Louis
Johnston, Joseph L., Springfield
Johnstone, John, Jr., Kirkwood
Jolly, Benjamin N., Mexico
Jolly, William H., Mexico
Jonas, Harry S., Jr., Kansas City
Jones, Andrew B., Soddy, Tenn. (Member St. Louis Medical Society)
Jones, Augustin, St. Louis
Jones, David N., Cape Girardeau
Jones, Dorothy J., St. Louis
Jones, Edna M., Clinton
Jones, Edward S., Harrisonville
Jones, Gale O., Kansas City
Jones, Grey, Eminence
Jones, Harold L., Springfield
Jones, James D. II, St. Louis
Jones, James H., St. Louis
Jones, Keith D., Warrensburg
Jones, Marion E., Kansas City
Jones, Otey S., St. Louis
Jones, Richard A., St. Louis
Jones, Samuel T., III, Kansas City
Jones, Sarah T., St. Louis
Jones, Theodore R., Kansas City
Jones, Victor, Brentwood
Jordan, Walter R., Long Beach, Calif. (Member St. Louis Medical Society)
Joseph, Donald J., Columbia
Joseph, Harold J., St. Louis
Joslyn, Harold L., St. Louis
Jost, Charles A., Florissant
Jotte, Richard F., St. Ann
Judd, Donald, St. Louis
Judge, Walter T., Crystal City
Judy, Joseph D., Florissant
Juergens, William G., St. Louis
Julien, Rene, St. Louis
Jung, J. Marshall, Illmo
Justus, John B., Kansas City

K

Kabir, Mohammed A., St. Louis
Kahler, Monte R., Bolivar
Kahn, Lawrence, St. Louis
Kahn, Marvin, Kansas City
Kairuz, Bartholome C., St. Louis
Kaiser, George C., St. Louis
Kallenbach, Glen P., Mexico
Kamada, Tsutomu, O'Fallon
Kamakas, Nicholas, Florissant
Kamal, Waseem, Columbia
Kamenetzky, Stephen A., St. Louis
Kaminski, Donald L., St. Louis
Kaminsky, Watson W., St. Louis
Kamuran, Ozgoncu, St. Louis
Kanagawa, Harold K., Jefferson City
Kanarek, Joseph, Kansas City
° Kandalaft, Fuad H., Dexter
Kandt, Ray E., Jr., Kansas City
Kane, Clyde E., St. Louis
Kang, Chang H., De Soto
Kang, Juan, St. Louis
Kang, Young M., St. Louis
Kannegiesser, Hartmut, St. Louis
Kantor, Julius M., Kansas City
Kantor, Samuel, Kansas City
Kao, Ming-Shian, St. Louis
Kaplan, Alex H., St. Louis
Kaplan, Michael F., Columbia
Kappesser, Netajean B., St. Louis
Kappesser, Roland C., St. Louis
Karandjeff, Apostle D., St. Louis
Karatela, Mohammed, St. Louis
Kardesch, Milton, St. Louis
Kardinal, Carl G., Columbia
Karl, Michael M., St. Louis
Karraker, Alvan G., Farmington
Karsh, Robert S., St. Louis
Kartus, Irving, Kansas City
Kaskie, Clifford R., St. Louis
Kasten, Melvin C., Cape Girardeau
Katf, Nicola, Kansas City
Kauffman, Ruth, Versailles
Kaufman, Andrew B., Kansas City
Kaufman, Kenneth R., St. Louis
Kaufman, Robert L., St. Louis
Kaufmann, Herbert H., Kansas City
Kaul, Philip G., Kansas City
Kaup, Chandra S., Ballwin
Kay, Billy F., Kansas City
Kayanan, Jose C., Kansas City
Kayes, Jack, St. Louis
Kays, Kenneth M., Columbia
Keairnes, Harold W., Kansas City
Keating, James P., St. Louis
Keefe, David M., St. Charles
Keeler, James E., Kansas City
Keenoy, John J., St. Louis
Keffler, Karl L., St. Louis
Keim, John H., Cape Girardeau
Keitzer, Walter Ford, Columbia
Keller, David W., St. Louis
Keller, Louis, St. Louis
Keller, Maurice J., St. Louis
Keller, Robert M., Wentzville
Kellett, John G., Webster Groves
Kelley, Gilbert B., Savannah
Kelley, Kenneth H., Poplar Bluff
Kelley, Robert W., St. Louis
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Kendall, Forrest H., Prairie Village, Kan. (Member Jackson County Medical Society)
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Kendig, John H., St. Louis
Kendis, Joseph B., St. Louis
Kennard, George K., Kansas City
Kenney, John D., St. Louis
Kenney, Roy E., Neosho
Kent, Bela K., Kansas City
Keohane, Mark K., St. Louis
Keown, Kenneth K., Columbia
Kernodle, Jefferson D., Kansas City
Kerr, David N., St. Louis
Kerr, Frank T., Monett
Kerr, Harold H., Kansas City
Kerr, S. Earl, Columbia
Kessler, Sheldon, Florissant
Ketterman, Grace H., Kansas City
Ketterman, Herbert L., Kansas City
Kettner, Edward G., Kansas City
Key, James S., Springfield
Key, Martin L., Ste. Genevieve
Keyes, Edward L., Clayton
Khan, A. Ghani, Arnold
Khan, Altaf Ali, St. Louis
Khan, Chung H., Waterloo, Ill. (Member St. Louis County Medical Society)
Khan, M. Osman, Maryville (Member St. Louis Medical Society)
Khodadoust, Kavous, St. Louis
Kieber, Robert W., St. Joseph
Kieffer, Victor B., Jr., Kirkwood
Kielar, Richard A., Fort Leonard Wood
Kiene, Richard H., Kansas City
Kienzle, Edward C., St. Louis
Kilburn, Kaye H., Columbia
Kilker, Clarence H., Normandy
Kilker, Donald E., Normandy
Killen, Duncan A., Kansas City
Kilo, Charles, St. Louis
Kim, Chung Ki, St. Louis
Kim, Jong Ku, St. Louis
Kim, Longius, Rivermines
Kim, Moon Young, St. Louis
Kim, Tchang Man, Tulsa, Okla. (Member Boone County Medical Society)
Kimball, Ireland W., Kansas City
Kimball, Merritt H., Kansas City
Kimberlin, Herbert C., Trenton
Kimble, Harvey S., Kansas City
Kimelman, Nathan, St. Louis
Kinder, Doyle D., Springfield
Kinder, James A., Cape Girardeau
Kinder, Jerry L., Cape Girardeau
Kindred, Lynn H., Kansas City
King, Elbert R., Boise, Idaho (Member West Central Missouri Medical Society
King, Eustace E., III, St. Louis
King, Francis C., Kirkwood
King, J. Tenbrook, Kansas City
King, James P., St. Louis
King, John V., Jr., Manchester
King, John V., St. Louis
King, Morris K., St. Louis
King, Phillip E., Liberty
King, Richard H., Clinton
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Kingsbury, Helen, Shawnee Mission, Kan. (Member Jackson County Medical Society)
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Kingsland, Robert C., St. Louis
Kinney, Sam E., St. Louis
Kinsella, Edward D., Richmond Heights
Kinsella, Peter W., St. Louis
Kinsella, Ralph A., Jr., St. Louis
Kinzie, Jeannie J., Shorewood, Wis. (Member St. Louis Medical Society)
Kipfer, Robert E., Springfield
Kipnis, David M., St. Louis
Kirkland, Jerry A., Kansas City
Kirkman, Robert E., Joplin
Kirstein, Melvin B., St. Louis
Kissane, John M., St. Louis
Kister, George E., St. Charles
Kistler, Walter D., Jr., St. Louis
Kistner, William F., St. Louis
Kitchen, William M., Kansas City
Klaus, Hanna, St. Louis
Klebba, Larry B., Jefferson City
Klein, Arnold G., St. Louis
Klein, Bert H., St. Louis

Klein, Edward H., Prairie Village, Kan. (Member Jackson County Medical Society)
Klein, Saul J., St. Louis
Kleinschmidt, Clinton, St. Louis
Klenk, Charles L., St. Louis
Kline, Carlyn M., St. Joseph
Kline, Edmund W., St. Joseph
Klingner, George M., Springfield
Klingner, George M., Jr., Springfield
Klinkerfuss, George H., Springfield
Klippel, Allen P., St. Louis
Klippel, Bernhardt W., St. Louis
Kloecker, Richard J., St. Ann
Kloecker, Robert P., St. Louis
Knabb, Kenneth E., Springfield
Kneal, E. Ellsworth, St. Louis
Kneibert, Fred L., Poplar Bluff
Knepper, Paul A., St. Joseph
Knight, F. P., Florissant
Knight, Lyle B., Lee's Summit
Knight, William A., Jr., St. Louis
Knipschild, Bedford F., Marshall
Knoch, H. Kermit, Kansas City
Knock, Henry L., Kirkwood
Knopf, Harry S. L., St. Louis
Knowles, R. R., St. Louis
Knowlton, Norman P., Jr., St. Louis
Kobbermann, Kobby J., Springfield
Koch, Robert E., Clayton
Kodner, Ira J., St. Louis
Koehler, George A., St. Louis
Koehler, John W., Joplin
Koenig, Marvin I., Florissant
Koerner, Kenneth A., St. Louis
Koessel, Arthur W., St. Louis
Kohler, Louis H., St. Louis
Koldys, Kenneth W., Cape Girardeau
Kolker, Allan E., St. Louis
Kolodny, Robert C., St. Louis
Kolze, Vernon W., Springfield
Konzelmann, John A., St. Louis
Koon, Ben H., Kansas City (Member Dallas-Hickory-Polk-Dade County Medical Society)
Koontz, Paul G., Kansas City
Kopman, Ercument A., St. Louis
Kopp, Jules H., St. Louis
Kopp, Leonard J., St. Louis
Kopperman, Mordecai, Kansas City
Koppers, Lawrence E., Kansas City
Kopta, Joseph A., Oklahoma City, Okla. (Member St. Louis Medical Society)
Korenblat, Phillip E., St. Louis
Korn, Robert L., Clayton
Korth, William M., Sarasota, Fla. (Member Jackson County Medical Society)
Kostianovsky, Jorge E., St. Louis
Kotner, Lawrence M., University City
Kovac, Albert P., Kansas City
Kovac, S. Robert, St. Louis
Kowert, Edward H., St. Louis
Kraeger, Russell, Glendale
Kraft, Jacob, Kansas City
Krahn, Henry C., Springfield
Kraner, Justin F., University City
Kranson, Seymour J., Independence
Kratz, Paul E., Cape Girardeau
Kraus, Fredrick T., St. Louis
Krause, G. Lynn, Jr., St. Louis
Krebs, Joseph M., St. Louis
Krewet, Frank A., III, St. Louis
Kroeger, George B., Jr., St. Louis
Krojanker, Rolf, St. Louis
Kromer, Charles, St. Louis
Kronemer, Norton S., St. Louis
Krupin, Barbara R., St. Louis
Krupin, Theodore, St. Louis
Kruse, Carl R., Palmyra
Kuangparichat, Manoch, Lexington
Kubin, Milford T., Pacific Grove, Calif. (Member Boone County Medical Society)
Kuczer, Arnoldo, St. Louis
Kuebrich, Thomas C., Ferguson
Kuenzi, Donald E., Kansas City (Member Clay County Medical Society)
Kuhlman, Ralph, St. Louis
Kuhlman, Robert E., St. Louis
Kuhn, John R., Jr., Joplin
Kuhn, Nobuko O., St. Louis
Kuhn, William F., II, Kansas City
Kulak, Gary, St. Louis
Kulkamthorn, S., St. Louis
Kulkamthorn, Sripatt, St. Louis
Kulowski, Jacob, St. Joseph
Kunawongsa, Nit, St. Louis
Kunz, Harold G., Jr., St. Louis
Kuo, Gong Ten, St. Louis
Kurtz, Karl J., Kansas City
Kuruvilla, George, Blue Springs
Kusama, Haruo, St. Louis
Kutryb, Walter J., Florissant
Kuttner, Marianne, St. Louis

Kuyakanon, W., St. Louis
Kwan, Vincente W., Potosi (Member St. Louis County Medical Society)
Kyger, John E., Independence

L

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Lachance, Leopold, Centralia
Lacson, Leticia D., Chesterfield
Lacy, Paul E., St. Louis
Ladd, Charles B., St. Louis
Ladenson, Roland P., Columbia
LaDriere, Raymond J., Creve Coeur
Ladyman, George H., Poplar Bluff
LaFerriere, Keith A., St. Louis
LaHue, William C., Lexington
Laird, John M., Jr., Florissant
Lally, James J., Kansas City
Lam, Albert, St. Louis
Lam, Ernesto S., St. Louis
Lam, Robert L., St. Louis
Lamar, Robert F., Kansas City
Lamb, Wanda, St. Louis
Lambert, Marian, Holly Hill, Fla. (Member Jackson County Medical Society)
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Lambie, Rodger W., Kansas City
Lampros, William P., St. Louis
Lamy, John E., Sedalia
Landau, William M., St. Louis
Landers, Burnell, Kansas City
Landhuis, L. R., Columbia
Landis, George K., Kansas City
Landry, J. Hubert, St. Louis
Lane, Clinton W., St. Louis
Lane, Daniel K., St. Louis
Lang, John J., St. Louis
Lange, Adolph C., St. Louis
Langeluttig, Harry V., El Dorado Springs
Langenbach, Alfred M., Ladue
Langevin, Jack, West Plains
Langlois, Paul J., St. Louis
Langston, Walter R., Springfield
Lanier, Earl W., St. Louis
Lankford, Harold D., Mexico
Lanning, R. James, N. Kansas City (Member Clay County Medical Society)
Lanning, Robert J., Hannibal
Lansangan, Isais, Arnold (Member St. Louis Medical Society)
Lansche, Elmer A., St. Louis
Lansche, W. Edward, St. Louis
Lapi, Angelo, Shawnee Mission, Kan. (Member Jackson County Medical Society)
Lapp, Harry C., Kansas City
Larocca, Felix E. F., St. Louis
Larsen, Kenneth V., St. Louis
Larsen, Virginia, St. Louis
Larson, Paul U., St. Louis
Lassar, Gilbert N., St. Louis
Latham, Kenyon S., California
Latham, Raymond W., Kansas City
Latimer, Walter N. A., Kansas City (Member Clay County Medical Society)
Lattinville, Henry E., Florissant
Lau, Luis, St. Louis
Lauber, Joseph J., St. Louis
Lauer, Daniel J., Kansas City
Lauer, John D., St. Louis
Laux, France A., St. Louis
Lawrence, George H., St. Louis
Lawrence, John R., Marshall
Lawton, John T., St. Louis
Lawton, Lawrence M., St. Louis
Layle, John K., Jr., Kansas City
Layton, Ira C., Kansas City
Leach, Wilfred, St. Louis
Leary, Daniel J., Jr., St. Louis
LeBlanc, Leo J., St. Louis
L'Ecuyer, Jerome L., St. Louis
Lederer, Charles M., Warrensburg
Lee, Carleton H., St. Joseph
Lee, Duk S., Chesterfield
Lee, Fransiska, St. Louis
Lee, Gerald B., Kansas City
Lee, Henry A., Kansas City
Lee, Jong Doo, St. Louis
Lee, King Ying, Kansas City
Lee, Larry, Kansas City
Lee, Sung Ae, Tulsa, Okla. (Member Boone County Medical Society)
Lee, Tae Hung, Kansas City
Leech, Charles A., Columbia
Leech, Maurice P., Fayette
Leeper, Claude K., Columbia
Leeper, Sidlee W., Columbia
Le Fevre, Philip J., Springfield
Legan, John K., Kennett
Lehman, Philip C., St. Joseph
Lehner, Richard L., Kansas City
Lehr, James L., Columbia

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Leidinger, Karl J., Republic
Leifer, William W., Kansas City
Leightner, William, St. Louis
Lembeck, Joseph A., St. Louis
Lemmon, George B., Jr., Springfield
Lenobel, Milton I., Clayton
Lentz, Clark H., Kansas City
Lentz, Harold C., Neosho
Leo, William A., Kansas City
Leonhardt, Erwin M., St. Louis
Leonidas, John C., Kansas City
Lepley, Rosalyn, Granite City, Ill. (Member St. Louis Medical Society)
Leroux, Gene H., Doniphan
Lerwick, Everett R., St. Louis
Leslie, Charles H., Kirkwood
Leslie, James T., Jr., Jefferson City
Lestmann, Henry E., Doniphan
Levey, Harry B., Kansas City
Levin, Marvin E., St. Louis
Levitt, Joseph, St. Louis
Levitt, Robert, St. Louis
Levy, Irwin, St. Louis
Levy, Jerome F., St. Louis
Levy, Morton A., University City
Lewellen, Charles H., Louisiana
Lewin, Wilbur H., St. Louis
Lewis, Charles R., Florissant
Lewis, James E., Jr., St. Louis
Lewis, Noel R., Strafford
Lewis, Revis C., Kansas City
Leydig, Stanley M., St. Louis
Liang, Howard S., St. Louis
Liang, Jing C., Independence
Liao, Kun T., St. Louis
Lichtor, Alexander, Kansas City
Lichtor, Joseph M., Kansas City
Lichty, Charles A., Shelbina
Lieb, Francis X., St. Louis
Lieberman, David M., St. Louis
Lila, Aram, Excelsior Springs
Lillard, Stephen B., Columbia
Lilly, Douglas R., St. Louis
Lim, Il Taik, St. Louis
Lim, Jet Kim, Columbia
Limpatakmonkol, P., Manchester
Limpiphiphatn, Dhajphone, Perryville
Limpiphiphatn, Ester, Perryville
Lin, Chi-Hsi, Springfield
Lin, Tai-Sun, St. Louis
Lindberg, Donald, Columbia
Lindeman, Carl H., St. Louis
Lindeman, John, Ballwin
Linder, Howard E., St. Louis
Lindgren, Carleton J., Kansas City
Lindquist, Carl N., Reeds Spring (Member Jackson County Medical Society)
Link, Alexander J., St. Louis
Link, Vance E., Independence
Lins, Robert D., Des Peres
Linsenmeyer, Charles M., St. Charles
Linville, Howard E., Kansas City
Lipschitz, Ervin, St. Louis
Lipsitz, Ellis S., St. Louis
Lischer, Carl E., St. Louis
Liss, Jay Lawrence, St. Louis
Lissner, Arthur B., O'Fallon
Little, Monroe H., St. Louis
Littlejohn, Robert T., N. Kansas City (Member Clay County Medical Society)
Littmann, Lewis E., St. Louis
Litton, Lyle D., Springfield
Litton, Lynn O., Columbia
Litwiller, R. W., Columbia
Litzow, Louis T., St. Louis
Livingston, Don, St. Louis
Lloyd, Ivan E., Kansas City
Lockhart, Charles E., Springfield
Lodwick, Gwilym S., Columbia
Loeb, Richard H., Springfield
Loeb, Virgil, Jr., St. Louis
Loeffel, Ellen S., St. Louis
Logie, MacDonald B., St. Louis
Logue, John T., Columbia
Lohmar, Roland E., Columbia
Lohr, Robert W., St. Louis
Lohrentz, Lois H., Shawnee Mission, Kan. (Member Jackson County Medical Society)
Loitman, Bernard, St. Louis
Londe, Alan M., St. Louis
Londe, Sol, St. Louis
London, Stanley L., St. Louis
Lonergan, Warren M., St. Louis
Long, Curtis W., Butler
Long, David S., Harrisonville
Long, Frank B., St. Louis
Long, R. Stacy, Kansas City
Longenecker, Joe L., Joplin
Lonsway, Maurice J., St. Louis
Lonsway, Maurice J., Jr., St. Louis
Lopansri, S., St. Louis
Lopez-Plata, Roberto, Kansas City
LoPiccolo, Vincent J., St. Louis
LoPiccolo, Vincent J., Jr., St. Louis
Lord, Richard E., Kirkwood
Lorenc, Ernest, Springfield
Lorenzo, Edilberto B., Kansas City
Lorenzo-Medina, Remedios, Kansas City (Member Clay County Medical Society)
Lottes, James O., St. Louis
Lotuaco, Gamaliel G., Kansas City
Loughead, John R., Poplar Bluff
Loutzenhiser, James K., Kansas City
Lovett, Robert L., Springfield
Lovinggood, Thomas A., Cape Girardeau
Lowe, Alvin L., Sedalia
Lowe, Horace A., Jr., Springfield
Lowell, Paul, Kansas City
Lowenstein, Paul S., St. Louis
Lowther, Gerald S., Chesterfield
Loyd, Earl L., Holts Summit (Member Cole County Medical Society)
Loynd, Robert C., St. Louis
Lucas, Bruce A., Lexington, Ky. (Member St. Louis Medical Society)
Lucas, Fred V., Columbia
Lucas, G. Elden, St. Louis
Lucido, Joseph L., St. Louis
Luckenbill, Paul T., Plattsburg
Luechtefeld, Frank, Kansas City (Member Clay County Medical Society)
Luedde, Philip S., St. Louis
Luehrs, Robert O., St. Louis
Lugo, Samuel, St. Louis
Luh, Andrew, St. Louis
Lum, Jon Tek, St. Louis
Lund, Herluf G., St. Louis
Lund, Robert H., Clayton
Lundgren, Fred H., Jr., Kansas City
Lundman, Hugh, Springfield
Lurie, Harold H., Springfield
Lusk, Charles A., Jr., Butler
Luther, George A., Kirkwood
Lutkewitte, Joseph F., Ste. Genevieve
Lutz, Martin H., St. Louis
Lyddon, Harold R., Jr., Kansas City
Lyle, Robert R., Versailles
Lyman, Edward H., St. Louis
Lynxwiler, Chester P., St. Louis
Lyss, Carl, St. Louis
Lyss, Stanley B., Clayton
Lyttle, Garnet C., St. Louis
Lytton, George J., Kansas City

Mc

McAdam, Charles R., St. Louis
McAfee, C. Alan, St. Louis
McAfee, R. Gordon, Kansas City
McAlhany, Howard J., Springfield
McAlister, William H., St. Louis
McAnelly, George C., Kansas City
McArtor, Thomas R., Browning
McBurney, Charles A., Slater
McCaffree, Mary K., Jefferson City
McCall, Edwin L., Kimberling City (Member St. Louis County Medical Society)
McCalla, John P., Kansas City
McCallister, Ben D., Kansas City
McCann, Louis P., Nevada
McCanse, Andrew, Kansas City
McCarthy, John M., St. Louis
McCarthy, Thomas D., Ferguson
McCaughan, John M., St. Louis
McClanahan, Robert C., Kansas City
McCloskey, R. Bruce, St. Louis
McCluer, Shirley, Columbia
McCluggage, Newton C., Kansas City (Member Clay County Medical Society)
McClure, David N., St. Louis
McClure, James N., Jr., St. Louis
McConahay, David R., Kansas City
McConchie, James E., Independence
McConnell, Robert G., Manchester
McCool, James F., Jr., St. Louis
McCord, E. Scott, Columbia
McCorkle, E. Lee, Marshall
McCormick, James E., Kansas City, (Member Clay County Medical Society)
McCormick, John R., St. Louis
McCown, Allan H., Kirkwood
McCoy, Frederick J., Kansas City
McCoy, Warren R., Caruthersville
McCraw, Doyle C., Bolivar
McCray, Glen M., Kansas City
McCrea, William A., Springfield
McCullough, Campbell C., Kansas City
McDaniel, John R., St. Joseph
McDermott, Alfred E., Perryville
McDonald, Eugene F., Jackson
McDonald, Herbert L., Kansas City
McDonald, Wallace, St. Joseph
McDonald, Wilbur P., St. Joseph
McDonnell, John F., Kansas City
McDonough, John, St. Louis
McElroy, Glenn L., Columbia
McEnery, Joseph P., St. Louis
McFadden, Gene A., Waverly
McFadden, James F., Sr., St. Louis
McFarland, H. Richard, Kansas City
McFarland, Morris D., Kansas City
McGannon, Paul T., Kansas City
McGinnis, Byron J., St. Louis
McGinnis, William F., St. Louis
McGinty, Charles P., Cape Girardeau
McGonigle, James P., Joplin
McGuire, Thomas H., Kansas City
McHaney, John W., Jefferson City
McIntosh, Donald E., Kansas City
McIntyre, John D., Kansas City
McKaskle, Clarence W., Caruthersville
McKee, Howard B., Joplin
McKee, Oliver A., Kirkwood
McKee, Wallace P., Kansas City
McKeel, Thomas B., Kansas City
McKinney, Joseph K., St. Louis
McKinsey, John J., Springfield
McKnelly, William V., Jr., Kansas City
McLane, Jerry F., Poplar Bluff
McLaughlin, Kathleen, St. Louis
McLaughlin, Richard D., Springfield
McLean, Harry A., Gig Harbor, Wash. (Member St. Louis Medical Society)
McLean, Royal C., St. Louis
McLelland, Bruce A., Columbia
McLeod, John, Kansas City
McMillan, Thomas E., Kansas City
McMurray, Herbert C., Manchester
McNabney, W. Kendall, Kansas City
McNalley, Michael, St. Louis
McNamara, John J., Richmond Heights
McNeel, Lee A., Jr., Greenfield
McNutt, Theodore L., Kansas City
McPhee, William R., Kansas City
McPheeters, James W., Poplar Bluff
McPike, Lloyd H., Joplin
McQueen, Samuel, Creve Coeur
McSwiney, John G., St. Louis
McVay, James R., Kansas City
McWherter, Lottie B., Shawnee Mission, Kan.
(Member Jackson County Medical Society)

M

Maben, Sam Edward, Kansas City
Macauley, Bernard J., Poplar Bluff
MacDonald, Robert R., Jr., St. Louis
Macdonald, William C., St. Louis
Macdonnell, Thomas M., Marshfield
MacGee, Edwin E., Kansas City
Machek, Otakar, St. Louis
MacInnis, Florence E., Kansas City
MacLaughlin, James C., Joplin
Macleod, Angus, St. Louis
MacNaughton, Ralph E., Blue Springs
MacNaughton, Robert A., Leawood, Kan. (Member Jackson County Medical Society)
Macnish, James M., St. Louis
Maddox, Albert R., Sedalia
Maddux, William P., Springfield
Madrid, Dominador, St. Louis
Magaletta, George E., Cape Girardeau
Magee, Robert L., El Dorado Springs
Magee, William E., St. Louis
Magill, Joseph S., Milan
Maginn, R. Reilly, St. Louis
Maginn, Richard L., St. Joseph
Magness, Guy N., University City
Magness, William C., Branson
Magruder, L. M., Nevada
Mahboubi, Aziz Olla, Sikeston
Mahe, George A., St. Louis
Maher, Robert W., Springfield
Maher, Thomas F., St. Louis
Malik, Sarfraz A., St. Louis
Mallouk, Alexander G., Kansas City
Mallow, James E., Kansas City
Maloney, Robert M., St. Louis
Malt, Sherwin H., St. Louis
Maminta, Napoleon S., Chesterfield
Manalo, Gil B., Jr., Carthage (Member Jefferson County Medical Society)
Manansala, Antonio Q., St. Louis
Mandler, George, Chillicothe
Manes, Jose, St. Louis
Manganaro, Frank J., St. Louis
Mangels, Kenneth A., Independence
Mangelsdorf, Thomas K., St. Louis
Manion, Maria E., St. Louis
Manion, Peter J., St. Louis
Manion, Thomas S., Independence
Manley, Charles B., Jr., St. Louis
Mann, James K., Hannibal
Manske, Paul R., St. Louis
Mantell, Jack M., Springfield
Mantovani, John, Jr., St. Louis
Manuel, Louis C., Kansas City
Maple, Francis M., Springfield

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Maranan, D. L., Kirkwood
Maravilla, Levy M., St. Louis
Marban, Manuel I., St. Louis
Marco, Philip J., Columbia
Marcus, Morris D., St. Louis
Mardini, Edward E., Bonne Terre
Margolis, Richard M., St. Louis
Marienfeld, Carl J., Columbia
Markel, Arthur D., Poplar Bluff
Marks, Mark M., Kansas City
Marmor, William A., St. Louis
Mars. Hartley F., Forsyth
Marsh, Alice, Pleasant Hill
Marshall, Cameron F., Shawnee Mission, Kan. (Member Jackson County Medical Society)
Marshall, Hal E., Kansas City
Marshall, William G., Glasgow
Marston, F. James, Jr., St. Joseph
Martel, Dominique, St. Louis
Martin, Andrew D., Sikeston
Martin, Clarence A., Joplin
Martin, Clyde V., Kansas City
Martin, Daniel J., St. Louis
Martin, David S., St. Louis
Martin, Frederick W., Jr., St. Louis
Martin, J. Barlow, St. Louis
Martin, James M., St. Louis
Martin, John N., St. Joseph
Martin, Thomas F., Granite City, Ill. (Member St. Louis Medical Society)
Martin, W. Joe, Louisiana
Martinez, Armando, St. Louis
Martz, John C., St. Louis
Mason, Wayne E., Kansas City
Massie, Edward, St. Louis
Masters, Edwin J., Sikeston
Masters, William H., St. Louis
Masucci, Joseph M., Kansas City
Mathew, M. S., Chesterfield
Mathew, Ruby R., St. Louis
Mathews, Robert, Kansas City
Matteson, Frank B., Grant City
Matthews, John G., St. Louis
Matthews, John I., Jefferson City
Mattis, Robert D., Clayton
Maughs, Sydney B., St. Louis
Max, Paul F., St. Louis
Maxey, Hugh W., Springfield, Ill. (Member Cole County Medical Society)
Maxson, T. Reed, Warrensburg
Maxwell, Richard W., St. Louis
May, Albert L., Jr., Poplar Bluff
May, Mark, Pittsburgh, Pa. (Member St. Louis Medical Society)
Mayer, John H., Jr., Kansas City
Mayer, Robert A., St. Louis
Mayer, William D., Columbia
Mayfield, James L., Crystal City
Mays, Frank G., Washington
Mayuga, Edgardo, St. Louis
Mayuga, Laureano G., Cabool
Meador, James R., St. Louis
Meadows, C. Douglas, St. Louis
Medler, John F., St. Louis
Medler, P. Louis, St. Louis
Medlicott, William J., Kansas City
Medrano, Crescenciano A., St. Louis
Medrano, Lina Ebro, St. Louis
Meegan, Robert J., Kansas City
Mehan, Donald J., St. Louis
Mehra, Ravinder B., St. Louis
Mehra, Usha, St. Louis
Mehta, Satish K., Kansas City
Meier, Francis X., Jefferson City
Meinberg, William H., St. Louis
Meiners, Paul N., St. Louis
Meiners, Theodore M., St. Louis
Meinershagen, Charles W., Jefferson City
Mejia, Hugo, St. Louis
Melgaard, S. Ross, Kansas City
Melick, William F., St. Louis
Mell, Roger L., St. Louis
Melson, G. Leland, St. Louis
Menchetti, Don E., Springfield
Mencias, Cristeta B., St. Louis
Mendelsohn, Robert S., St. Louis
Mendelson, David F., St. Louis
Mendez, Manuel M., St. Louis
Menendez, Manuel F., Ballwin
Menendez, Silvana, Ballwin
Mendonsa, Lawrence E., St. Louis
Meneses, Orlando G., St. Louis
Menne, Marvin G., Ironton
Mentgen, Carl N., Springfield
Merenda, Sam J., St. Louis
Merideth, Mary Jane, Cassville
Meriwether, Don R., St. Joseph
Merrims, Theodore, St. Louis
Merritt, Burch A., St. Louis
Merveille, Octave C., Kansas City
Merz, Jean J., Creve Coeur
Mestres, Hugh M., St. Louis
Metz, Charles O., St. Louis
Metzl, Kurt, Kansas City
Meyer, Herman M., University City
Meyer, James E., Manchester
Meyer, Jay, Clayton
Meyer, Jerry L., Concordia
Meyer, John S., St. Louis
Meyer, Melvin E., St. Louis
Meyer, Paul W., Kansas City
Meyers, David S., Columbia
Meyers, Elsie F., St. Louis
Meyers, Harold L., Kansas City
Meyers, Jerry, St. Louis
Meyers, John B., Clayton
Meyers, Robert W., St. Louis
Mezera, Raymond A., St. Louis
Michael, Harvey R., Springfield
Michael, Kenneth D., St. Louis
Michael, Vernon E., St. Louis
Michaelree, John F., St. Louis
Miciano, Ruel T., Buckner
Middleton, Jerry N., St. Louis
Middleton, John W., Louisiana
Mier, Thomas M., St. Louis
Milder, Benjamin, St. Louis
Miles, George O., Kansas City
Miles, Glenn E., Louisiana
Miles, Paul W., St. Louis
Milgram, Byron A., Kansas City
Mill, William B., Jr., St. Louis
Millangue, Consolacion P., St. Louis
Millangue, Rafael M., St. Louis
Miller, Charles, Jr., Kirkwood
Miller, Clinton L., Lee's Summit
Miller, Clyde S., Waynesville
Miller, D. Herbert, Tulsa, Okla. (Member Chariton-Macon-Monroe-Randolph County Medical Society)
Miller, David V., Poplar Bluff
Miller, Edward J., St. Louis
Miller, Geoffrey W., St. Louis
Miller, Gerald L., Kansas City
Miller, James E., St. Louis
Miller, James R., St. Louis
Miller, Jule P., Jr., St. Louis
Miller, Leroy J., Columbia
Miller, Max I., Prairie Village, Kan. (Member Jackson County Medical Society)
Miller, Norman C., St. Louis
Miller, Robert N., St. Louis
Miller, William V., St. Louis
Miller, Wilson H., Kansas City
Millikan, Larry E., Columbia
Milne, J. L., Springfield
Milstead, Kenneth L., Jr., Hazelwood
Milster, Clyde R., St. Louis
Miltenberger, Paul C., Kennett
Minnigerode, Lanak, Kansas City
Minnigerode, Turner L., Kansas City
Minnihan, Robert W., Chesterfield
Minton, Robert S., St. Joseph
Mirbaha, Mitchell M., St. Louis
Mishkin, Marvin R., St. Louis
Miskovsky, Emil F., St. Louis
Missey, Wilburn C., Jr., St. Louis
Mitchell, Andrew D., Kansas City
Mitchell, Eugene, St. Louis
Mitchell, Franklin L., Columbia
Mitchell, John D., Kansas City
Mitchell, Lynn D., Columbia
Mitchell, Robert H., Kansas City
Mitchell, Roy E., Salem
Mitchell, Thomas J., St. Clair
Mitra, Nirmal K., Kansas City
Mixson, William C., Kansas City
Moallempour, Issa, St. Louis
Modjtehedy, M. H., St. Louis
Moellenhoff, Robert W., Washington
Moeller, F. Delbert, St. Louis
Moen, Berwyn H., St. Joseph
Molden, Charles A., Normandy
Monafo, William W., Jr., St. Louis
Monat, Seymour, St. Louis
Monroe, C. Dean, Columbia
Monta, Mande D., St. Joseph
Montani, Charles, St. Louis
Montellano, Arturo H., Monett
Montello, Samuel A., Kansas City
Montes, Arturo C., St. Louis
Montes-de-Oca, Julio, St. Louis
Montgomery, Austin F., St. Louis
Montgomery, Gordon J., St. Louis
Montie, Joseph E., Columbia
Moolsintong, P., St. Louis
Moon, Thomas R., Jr., St. Louis
Mooney, Justin L., Shawnee Mission, Kan. (Member Jackson County Medical Society)
Mooney, Marcel L., Kansas City
Moore, Alva, St. Louis
Moore, De Armond, Springfield
Moore, Harry G., St. Louis
Moore, Harry G., Jr., St. Louis
Moore, Robert A., Kansas City
Moore, Walter L., St. Louis
Moran, Thomas M., St. Louis
Moranville, Benedict A., Columbia
Moreano, Armando H., Kansas City
Morehead, William E., Malden
Morest, F. Stanley, Springfield
Morgan, David B., Kansas City
Morgan, Harry C., St. Louis
Morgan, Philip E., Columbia
Morgan, Stephan S., St. Louis
Morgan, Troy O., Jr., Albany
Morgan, W. Thomas, Jr., West Plains
Morgan, William R., Kansas City
Moritz, Gerald W., St. Louis
Morley, Louise A., Shawnee Mission, Kan. (Member Jackson County Medical Society)
Morrin, Kevin C., St. Louis
Morris, Alan H., St. Louis
Morris, Harvey E., St. Louis
Morris, Joseph H., Jr., Kansas City
Morris, Mary E., St. Louis
Morris, R. William, St. Louis
Morrison, Arlen, St. Louis
Morrison, Donald H., Shawnee Mission, Kan. (Member Jackson County Medical Society)
Morrison, J. Scott, Kansas City
Morrison, T. A., Aurora
Morse, John P., St. Joseph
Morse, Marvin, St. Joseph
Mortensen, Frede, St. Louis
Morton, Paul C., Springfield
Mosbacher, Hugh E., Independence
Mosby, Larry Dee, Columbia
Moseley, F. Thomas, Springfield
Moses, Robert A., St. Louis
Mosquera, Jaime, Florissant
Moss, Paul, Kansas City
Mosser, Robert S., Kansas City
Mothershead, John L., St. Joseph
Motzel, Albert J., St. Louis
Mou, Bin, Nevada
Mountjoy, Grace S., Clayton
Mowrer, Marie O., St. Louis
Mowrey, William O., Jennings
Muckerman, Richard I. C., St. Louis
Mudd, J. Gerard, St. Louis
Muelheims, Gerhard H., St. Louis
Mueller, Adolph R., Jr., Joplin
Mueller, Clarence E., Creve Coeur
Mueller, Joseph A., St. Louis
Mueller, Martin J., Kansas City
Mueller, Morris A., San Antonio, Tex. (Member St. Louis Medical Society)
Mueller, Robert, St. Louis
Mueller, Robert J., St. Louis
Mueller, Wilbur K., St. Louis
Muench, Albert H., St. Joseph
Muenster, Vincent P., St. Charles
Muhm, Harvard Yale, St. Charles
Mullarky, Wilbur A., Chesterfield
Mullen, Jack, Bonne Terre
Mullen, Leo M., Kansas City
Mullen, Mary E., St. Louis
Mullican, Charles, St. Joseph
Mulligan, Leo V., St. Louis
Mullinax, Orr, St. Joseph
Mullins, Bernard L., N. Kansas City
Mullins, John E., St. Louis
Mullins, Maurice F., Columbia
Mundy, William L., Kansas City
Murdock, Nathaniel H., St. Louis
Murney, Joseph A., Washington
Muro, F. Del, Kansas City
Murphy, Bernard L., Hannibal
Murphy, George E., St. Louis
Murphy, James J., Kansas City
Murphy, James P., St. Louis
Murphy, John C., St. Louis
Murphy, Michael G., St. Louis
Murphy, Robert J., Kansas City
Murray, John P., St. Louis
Murray, Wilber L., Kansas City
Muschany, Norman K., St. Louis
Musgrave, David E., Excelsior Springs
Mussell, Howard L., Columbia
Muth, Robert G., Kansas City
Myers, Andrew I., Kansas City
Myers, Carl M., Kansas City
Myers, David W., Jr., Smithville
Myers, Gary H., St. Louis
Myers, George H., Kansas City
Myers, Ivan T., St. Louis
Myers, James M., Rolla
Myers, John S., Kansas City
Myers, Robert M., Kansas City

N

Nagi, Kamal, St. Louis
Nahm, Chung Chick, St. Louis
Naime, Mansour J., Kansas City

° Doctor of Osteopathy.

Nakada, James R., St. Louis
Nalagan, Marcos C., St. Louis
Napper, Marvin L., Springfield
Naryka, Joseph J., St. Louis
Naseer, Raiz A., St. Louis
Nash, Helen E., St. Louis
Nathan, Lester J., St. Louis
Navarro, Manuel I., Columbia
Navato, Jose, Manchester
Near, David M., Florissant
Nelson, Bentley A., Kansas City
Nelson, David E., Springfield
Nelson, J. Roger, Kirkwood
Nelson, James S., Clayton
Nemec, Edward S., St. Louis
Nemec, Stanley S., St. Louis
°Nemer, Robert J., Vienna (Member Cole County Medical Society)
Ness, Carl K., St. Joseph
Nesselrode, John H., Independence
Nester, Charles A., St. Louis
Neu, Leo T., Jr., Springfield
Neubeiser, Ben L., St. Charles
Neukom, George B., Farmington
Neumann, James W., Kansas City
Neun, William F., St. Louis
Newcomb, Arthur D., Lamar (Member Mineral Area County Medical Society)
Newman, Matthew, St. Louis
Newman, Percy, St. Louis
Newman, Robert L., Kansas City
Newmark, Leonard N., St. Louis
Newport, Gerald, St. Louis
Newton, Gordon, St. Louis
Newton, William T., St. Louis
Nichols, W. Kirt, Columbia
Nickel, James F., St. Louis
Nickels, Mathew L., Louisiana
Nicolai, Charles H., St. Louis
Nicolay, Bill, Fredericktown
Niedermeyer, Edward L., Tarkio
Niedermeyer, George J., St. Louis
Niesen, Frank J., St. Louis
Nieuwenhuizen, Maarten, Columbia
Nieva, Delfin T., St. Louis
Nigh, Charles A., St. Louis
Nigro, E. Robert, Shawnee Mission, Kan. (Member Jackson County Medical Society)
Nigro, Joseph A., Kansas City
Nishi, Toshio, St. Louis
Nixon, Edward E., Gallatin
Noback, Richardson K., Kansas City
Nolan, Charles J., St. Louis
Noller, Henry W., Overland
Nolph, Georgia B., Columbia
Noltensmeyer, Milton N., Shawnee Mission, Kan. (Member Jackson County Medical Society)
Nomura, Roy M. Y., St. Louis
Norland, Charles C., St. Louis
Noronha, R. F. X., St. Louis
Nouhan, Joseph G., Jr., St. Louis
Nourbakhsh, Mahmoud M., Platte City (Member Clay County Medical Society)
Nouri, Hassan, St. Louis
Novak, Edward J., Kansas City
Nuetzel, John A., St. Louis
Nukrongsin, Somporn, St. Louis
Nunez, Maria M., St. Louis
Nunnelly, Gordon M., Cape Girardeau
Nussbaum, Robert A., St. Louis
Nye, Robert S., St. Louis

O

Oakley, Margaret M., St. Louis
Obadina, Olukunle O., St. Louis
Obando, Francisco J., Troy
O'Bannon, Lon W., Jr., Florissant
Obermeyer, Charles G., St. Louis
O'Brien, Edward C., St. Louis
O'Brien Edward J., St. Louis
O'Brien, Harry F., Mexico
O'Brien, Liam, St. Joseph
O'Brien, Robert M., St. Louis
Oceeno, Victor G., Monett
O'Connor, Robert J., Florissant
O'Connor, William B., St. Joseph
O'Donnell, Joseph V., St. Louis
O'Dowd, James A., St. Louis
Oehler, William F., Cape Girardeau
Oestreich, Alan, Columbia
Oetter, Donald L., St. Louis
O'Farrell, Thomas P., Kansas City
Oglesby, Richard B., St. Louis
Ognyanov, V. F., St. Louis
Ogura, Joseph H., Ladue
O'Hearne, John J., Kansas City
Ohlms, David L., St. Louis
Ohmoto, Masao, St. Louis
Ojascastro, Alejandro C., St. Louis
O'Keefe, Joseph D., St. Louis
O'Kell, Richard T., Kansas City
Okun, Edward, St. Louis
Olive, George C., Neosho
Oliver, George A., Farmington
Olmsted, William H., St. Louis
Olney, John W., St. Louis
Olson, Elbert R., Springfield
Olson, Richard O., Jr., St. Charles
Olson, Robert E., St. Louis
O'Malley, James F., Kansas City
O'Neal, Lawrence W., St. Louis
O'Neal, Patricia, St. Louis
O'Neil, James H., Shawnee Mission, Kan. (Member Jackson County Medical Society)
Ong, Eng L., St. Louis
Ong, Ofelia, St. Louis
Oppenheimer, Henry E., Clayton
Ordoukhanian, Tatool, St. Charles
O'Reilly, D. Elliott, St. Louis
Orenstein, Joseph M., St. Louis
Orgel, M. Norman, St. Louis
Orgel, Michael, St. Louis
Orille, Oscar P., St. Louis
Orsay, Paul K., St. Louis
Orszulak, Thomas A., St. Louis
Orth, Oliver G., Columbia
Ortiguero, Leopoldo M., St. Louis
Ortillo, Amado P., St. Louis
Ortmeyer, Leroy F., St. Louis
Osborne, Jere O., Kansas City
Osbourn, Richard A., Fulton
Ossman, Julian A., Jefferson City
Ost, Mark D., Kansas City
Ostapowicz, Frank, St. Louis
O'Sullivan, Daniel F., St. Louis
O'Sullivan, George A., St. Louis
Ott, F. Thomas, Glendale
Ott, Harold J., II, St. Louis
Ott, Harold J., Maplewood
Ott, William J., St. Louis
Ottensmeyer, Charles D., Springfield (Member St. Louis County Medical Society)
Otto. Thomas G., Cape Girardeau
Ottolini, James L., Creve Coeur
Overend, Donald S., Springfield
Overesch, Harry B., Kansas City
Overholser, Milton D., Columbia
Owen, Robert F., St. Louis
Owens, James L., Kansas City
Owens, John H., Sedalia
Owens, Richard L., Kansas City
Owens, Robert H., Kansas City
Owens, William D., St. Louis
Ozar, Milton B., Kansas City
Ozenberger, Larry A., Plattsburg
Ozmat, Orhan, St. Louis

P

Pack, Gary L., Kansas City
Packman, Robert C., St. Louis
Paculdo, Nora R., St. Joseph
Paddock, Charles S., Joplin
Padilla, Teresita C., St. Louis
Paez, Mauro A., St. Louis
Page, Jesse W., Sikeston
Paine, Robert, St. Louis
Painter, Andrew E., Portageville
Painter, Lattie B., Jr., Portageville
Pakula, Sidney, Kansas City
Pal, Nirmal K., Bonne Terre
Palazzo, Frank A., St. Louis
Palcheff, Chris L., Springfield
Palenske, Robert L., Hornersville
Paletta, Francis X., St. Louis
Paletta, Theodore L., St. Louis
Pappalardo, Carlos, St. Louis
Pardo, Leopoldo P., Jr., St. Charles
Parelman, Allen G., Kansas City
Paris, William H., Normandy
Park, Agatha Lee, St. Louis
Park, Duk Jae, Festus
Park, Kun H., St. Louis
Park, William I., Jr., Springfield
Parker, Arthur C., Jr., Poplar Bluff
Parker, Hubert M., Kansas City
Parker, Thomas W., University City
Parker, William, St. Louis
Parkison, Donald E., Seligman
Parlato, George S., Springfield
Parsi, Manutchehr K., Pittsburg, Kan. (Member St. Louis Medical Society)
Parsons, D. LeRoy, Cape Girardeau
Parsons, Eugene O., Stanley, Kan. (Member Jackson County Medical Society)
Parsons, Richard P., St. Louis
Partamian, Krikor O., St. Joseph
Partap, Prabha, St. Louis
Parulekar, D. G., Florissant
Parwatikar, Sadashiv D., St. Louis
Pascoe, James J., Nevada
Pasia, Ebello T., Florissant
Passanante, Bartholomew M., St. Louis
Patrick, Roman L., Jr., St. Louis
Patterson, Carroll D., Kansas City (Member Clay County Medical Society)
Patterson, Donald R., Joplin
Patterson, Grover S., Carthage
Patterson, John F., Marshfield
Patton, Douglas S., St. Louis
Paul, Paul V., St. Louis
Paulson, Gordon S., St. Joseph
Pavlu, Robert R., Waverly
Pawol, S. E., Bridgeton
Pawsat, John E., Kansas City
Payne, David E., Columbia
Payne, John W., Columbia
Payne, Meredith J., St. Louis
Payne, Vaughn C., St. Louis
Pearlman, Alan L., St. Louis
Pearman, Carl C., Columbia
Pearse, Roy W., Jr., Nevada
Pearson, Paul E., Kansas City
Pecoraro, Anthony P., Kansas City
Peden, Burnet W., Clayton
Peden, James C., Jr., St. Louis
Peden, Joseph C., St. Louis
Peden, Joseph C., Jr., St. Louis
Pedersen, Harold J., St. Louis
Peebles, J. B., Jr., Kirkwood
Peete, Don C., Kansas City
Pelegrin, Robert J., Independence
Pelican, George, Columbia (Member St. Louis County Medical Society)
Pelz, Mort D., St. Louis
Pemberton, L. Beaty, Kansas City
Pence, F. Wendell, Carthage
Pendell, Paul W., Rolla
Penilla, Antonio R., Bridgeton
Penner, Stanley, Kansas City
Penninger, William H., Springfield
Pennington, Francis E., St. Louis
Pennoyer, James, Webster Groves
Pepper, Edward G., St. Louis
Pepper, Max, St. Louis
Perez, Adamor R., St. Louis
Perez, Blanca M., St. Louis
Perez, Carlos A., St. Louis
Perez, Raul A., St. Louis
Perez, Romulo G., Troy
Perez-Mesa, Carlos, Columbia
Perico, Carlos J., Kansas City
Perkins, David E., St. Louis
Perkoff, Gerald T., St. Louis
Perll, Maurice F., Kansas City
Perll, Rita D., Kansas City
Perna, Vincent P., Creve Coeur (Member St. Charles-Lincoln County Medical Society)
Pernoud, Flavius G., Jr., St. Louis
Pernoud, Michael F., St. Louis
Perry, H. Mitchell, St. Louis
Perry, Ralph, Kansas City
Perry, William D., St. Louis
Petersen, Eugene G., Lee's Summit
Petersen, Harold E., St. Joseph
Peterson, Bonita J., Kansas City
Peterson, Carl M., Kansas City
Peterson, Charles R., Columbia
Peterson, Donald B., Fulton
Peterson, Frederick D., St. Louis
Peterson, George L., Kansas City
Peterson, Stanley S., Springfield
Peterson, Vernon J., Topeka, Kan. (Member Boone County Medical Society)
Peterson, Walter R., Kansas City
Petit, Carl A., Kansas City
Petruska, Paul J., St. Louis
Petry, Ezra L., Lenexa, Kan. (Member Jackson County Medical Society)
Pfefer, Leland U., Columbia
Pfeffer, Robert I., St. Joseph
Pfefferkorn, David, St. Louis
Pfeifer, Oliver C., St. Louis
Philip, Varkey, St. Louis
Phillips, Abraham M., St. Louis
Phillips, Granville J., Jr., El Paso, Tex. (Member St. Louis Medical Society)
Phillips, Hanford, St. Louis
Phillips, John J., St. Louis
Phillips, William J., St. Louis
Philpott, Gordon W., St. Louis
Phipatanakul, Chintana, Florissant
Phipatanakul, Supote, St. Louis
Piccione, Leonard N., St. Louis
Pichardo, Javier, Farmington
Pickard, Clarence M., Columbia
Pickard, Nicholas S., Shawnee Mission, Kan. (Member Jackson County Medical Society)
Pickens, E. Allen, Fulton (Member West Central Medical Society)
Pickens, James Milton, Columbia
Pickering, Lee I., Independence
Piebenga, Larry W., Kansas City

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Piepergerdes, Larry G., Kansas City
Pifer, Lawrence H., St. Joseph
Pileggi, Felix A., N. Kansas City
Pilla, Lawrence A., St. Louis
Pimentel, Esperanza, St. Louis
Pineda, Hector O., St. Louis
Pingelton, William B., Columbia
Pinkerton, Joseph A., Jr., Kansas City
Pinkstaff, Thomas H., Sikeston
Pinsker, Oscar T., Kansas City
Pinto, John F., St. Louis
Piper, August T., St. Louis
Piper, Donald K., Kansas City
Pipes, Keith E., St. Louis
Pipkin, Garrett, Clinton (Member Jackson County Medical Society)
Pitsinger, Nolan B., St. Louis
Pittman, Gerald, St. Louis
Pittman, Susan, St. Louis
Pitts, Ferris N., Jr., St. Louis
Pizzimbono, Carlos A., Highland, Ill. (Member St. Louis Medical Society)
Place, K. Craig, Kansas City
Platt, William R., St. Louis
Platz, John H., Carrollton
Plax, Steven, St. Louis
Plesons, John D., St. Louis
Plowman, Edward M., Hannibal
Plumpe, W. Tupper, St. Louis
Plunkett, Littleton J., Jr., Poplar Bluff
Podos, Steven M., New York, N. Y. (Member St. Louis County Medical Society)
Podrecca, Guido I., Springfield
Poggemeier, William H., Jr., St. Charles
Pojanasomboon, Pichat, Rolla
Politi, Gregory, Kansas City
Politte, Lenard L., Columbia
Pollock, Leo H., Kansas City
Pontillas, Job B., Perryville
Poonawala, Huseni E., Kansas City
Poor, Carl W., Neosho
Pope, Charles H., Jr., Kansas City
Popp, Carl G., Sikeston
Porporis, Arthur A., St. Louis
Porter, Louis, Kansas City
Porter, Michael J., Kansas City
Portugal, Antonio Q., St. Louis
Portuondo, Bonaventura C., St. Louis
Post, John P., Washington
Post, Lawrence T., Jr., St. Louis
Post, Stephen L., St. Louis
Post, Winfred L., Joplin
Potashnick, Robert, St. Louis
Potter, Caryl A., Jr., St. Joseph
Potter, Lee G., Kansas City
Potter, Reese H., St. Louis
Potts, Donald A., Independence
Powell, Alan E., Independence
Powell, Charles B., Florissant
Powell, Earl A., St. Louis
Powell, Edwin M., Springfield
Powell, Nelson E., Kansas City
Powell, Robert G., Joplin
Powers, John M., Independence
Powers, Pierce W., St. Louis
Powers, William E., St. Louis
Prater, Bill G., Springfield
Pratt, Lindsay L., St. Louis
Prendergast, Thomas John, Jr., Columbia
Prensky, Arthur L., St. Louis
Presnell, Cleitus A., St. Louis
Price, Kenneth C., St. Louis
Prieto-Basa, Nenita, St. Louis
Printz, Joseph H., Kansas City
Printz, Otto J., Kansas City
Probst, Raymond E., St. Louis
Probstein, Jacob G., St. Louis
Proctor, Donald C., Sedalia
Prokop, Joseph R., St. Joseph
Prophete, B., St. Louis
Proskey, Vincent J., St. Louis
Pruett, Burchard S., St. Louis
Pruett, Don S., St. Louis
Pruett, Hubert S., St. Louis
Pruett, Paul L., Springfield
Prusaczyk, Joseph, Florissant
Pryor, Ira Joe, Joplin
Pu, Pin H., Kennett
Pucci, Gregory L., Kansas City
Pugh, Daniel D., St. Louis
Pugh, Reginald P., Pittsburgh, Pa. (Member Boone County Medical Society)
Pugh, Richard G., Independence
Pulliam, Morris W., St. Louis
Punhong, Prasert, Lubbock, Tex. (Member St. Louis Medical Society)
Purcell, Harry K., St. Louis
Purcell, Paul L., Smithville (Member Marion-Ralls-Shelby County Medical Society)
PuthenPurackal, George, St. Louis
Pyne, Herbert S., St. Louis
Pyron, Katharine A., Gulfport, Miss. (Member Clay County Medical Society)

Q

Quer, Erich A., Kansas City
Quick, Richard T., St. Louis
Quinn, Paul S., Springfield

R

Rabin, Erwin R., Topeka, Kan. (Member St. Louis County Medical Society)
Raborar, Arteso C., Springfield
Racadio, Severo M., Kirkwood
Racela, Antonio S., Jr., Kansas City
Rachlin, Maxwell, St. Louis
Rader, Ada B., Kansas City
Rader, Edward S., St. Louis
Rader, George B., St. Louis
Radke, John D., St. Louis
Ragland, Jerry, Warrensburg
Ragland, John E., Ballwin
Rahman, Mohammad H., St. Charles
Rahman, Moududur, St. Louis
Raich, Robert A., Kansas City
Raichle, Marcus E., St. Louis
Rainey, Robert, St. Louis
Rainwater, Elmer H., Springfield
Raksakulthai, V., Fredericktown
Rall, Kenneth L., Columbia
Ramey, Ehret O., Kansas City
Ramirez, Ricardo M., Poplar Bluff
Ramirez, Samuel G., St. Louis
Ramos, Americo G., Kansas City
Ramsey, Robert H., Florissant
Randolph, Bernard C., St. Louis
Rankin, Diane, St. Louis
Rannie, Paul R., Independence
Rao, A. R., Fredericktown
Rao, Carlo, St. Louis
Rao, S. N., St. Louis
Rao, V. Padmanabha, Springfield
Raper, Charles A., Poplar Bluff
Raphel, Jose, St. Joseph
Rapp, Earl L., Hannibal
Rapp, Harold B., Cape Girardeau
Rappold, H. O., St. Ann
Ratcheson, Robert A., St. Louis
Ratkin, Gary A., St. Louis
Ratnam, Dasari V., Kansas City
Rauch, James E., Kansas City
Ravis, Mark S., Kansas City
Rawlins, Fred E., Cape Girardeau
Raybuck, Harry E., St. Louis
Raynor, Richard, Marshall
Raza, Syed A., St. Louis
Razek, A., Maryland Heights
Reardon, Thomas F., St. Louis
Recano, Ricardo Q., St. Louis
Rector, Joe L., Jr., Kansas City
Reddin, Jack L., Independence
Reddin, Patrick C., Mexico
Reddy, Abbiah N., Poplar Bluff
Reddy, Sarvotham K., Poplar Bluff
Redington, James C., Jr., Clayton
Redmond, John W., St. Louis
Redmond, William, St. Joseph
Reed, G. H., Appleton City
Reed, William A., Kansas City
Reeder, Charles C., Smithville
Reese, A. Victor, St. Louis
Reese, Lester T., St. Louis
Reeves, Glen I., University City
Regier, Carl M., Branson
Reh, Thomas E., St. Louis
Rehm, Ralph, Dexter
Reich, Harry A., St. Louis
Reichert, M. Cecelia, St. Louis
Reid, James A., Marshall
Reider, Richard A., Warson Woods
Reineck, John A., St. Louis
Reinhard, Edward H., St. Louis
Reinhardt, George R., Kansas City
Reisa, Ronald C., St. Charles
Reisler, David M., St. Louis
Reiss, Jeanne E. L., Kansas City
Reister, Dorothy D., Shawnee Mission, Kan. (Member Jackson County Medical Society)
Reister, Philip D., Kansas City
Reitman, Stanley, St. Louis
Rejent, Anthony, St. Louis
Rendleman, David D., Clayton
Rendleman, George F., St. Louis
Rendleman, George, Jr., St. Louis
Rengachary, Dhanalakshmi, Kansas City
Rennard, Marvin, St. Louis
Repaso, Florante A., Sullivan (Member St. Louis County Medical Society)
Repp, Theodore J., St. Louis
Reuter, Louis A., St. Louis
Revare, Paul, Kansas City
Reveley, Michael, St. Louis
Reyes, Jose T., St. Louis
Reyes, Luis A., St. Louis
Reyes, Rosendo A., St. Louis
Reynolds, Clarence C., Kansas City
Reynolds, Fred, St. Louis
Reynolds, James A., Warson Woods
Reynolds, M. Wayne, Warrensburg
Rhee, Dong S., St. Louis
Rhee, Seoung Eun, St. Louis
Rhoades, Arthur B., Shawnee Mission, Kan. (Member Jackson County Medical Society)
Rhodes, Andrew J,. Kansas City
Rhodes, Philip G., Kansas City
Ricci, Walter F., Kansas City
Rice, Ronald, St. Charles
Richany, Shafik F., Kansas City
Richards, Frank O., St. Louis
Richardson, George A., Union
Richardson, Marion W., Kansas City
Richardson, Thomas F., St. Louis
Richardson, William R., Union
Richert, Robert C., Kansas City
Richman, Elmer, Chesterfield
Richmond, Michael R., Florissant
Ridenhour, C. E. Gene, Columbia
Ridgeway, William G., St. Louis
Ridings, Harold D., Cape Girardeau
Riekhof, Paul L., Kansas City, Kan. (Member Jackson County Medical Society)
Ries, Douglas A., St. Louis
Riffel, Gordon W., Bourbon
Riggio, Salvatore N., St. Louis
Rigney, Levi M., Springfield
Rikli, Arthur E., Columbia
Riley, Charles T., Richmond
Riley, John J., St. Louis
Riley, Joseph P., Jr., Parthenon, Ark. (Member Jackson County Medical Society)
Riller, Lowell E., Kansas City
Rinck, Edward C., Nevada
Ring, Edward M., St. Louis
Rink, Richard A., Columbia
Riordan, Robert H., Kansas City (Member Clay County Medical Society)
Rippey, John H., Kansas City
Rising, Dean R., Springfield
Ritchie, Frances R., St. Louis
Ritter, C. John, Cape Girardeau
Ritter, Carl F., Cape Girardeau
Ritter, Hubert A., St. Louis
Ritter, Paul J., St. Louis
Ritter, Raymond A., Cape Girardeau
Ritter, Raymond A., Jr., Cape Girardeau
Ritterbusch, James K., Fulton
Rizzo, Adolfo E., St. Louis
Rizzo, Marco, Honolulu, Hawaii (Member St. Louis Medical Society)
Roach, Edward A., St. Charles
Roark, Michael, St. Louis
Robb, Harold Phillip, Jefferson City
Robben, G. Garry, St. Louis
Roberts, Grosvenor G., Lee's Summit
Roberts, Harold K., Clayton
Roberts, Harold M., Kansas City
Roberts, Howard H., Joplin
Roberts, John P., Kirkwood
Roberts, John R., St. Louis
Roberts, Paul A., Sweet Springs
Roberts, Perry, Cape Girardeau
Roberts, Phyllis Grant, St. Joseph
Roberts, William V., Jr., St. Louis
Robertson, Frank G., St. Louis
Robertson, William D., Poplar Bluff
Robertson, William D., Kansas City
Robinett, Wade V., Kansas City
Robins, Eli, St. Louis
Robinson, Arthur W., Kansas City
Robinson, Edith C., St. Louis
Robinson, E. Kip, Kansas City
Robinson, Gary Lewis, Springfield
Robinson, George G., Humansville
Robinson, Van M., N. Kansas City (Member Clay County Medical Society)
Robinson, William J., Kansas City
Roblee, Melvin A., St. Louis
Robles, Luis H., Lee's Summit
Roche, Maurice B., St. Louis
Rodas, Rizalina, Kansas City (Member Clay County Medical Society)
Roddy, Hugh John, Denver, Colo. (Member St. Louis County Medical Society)
Roden, Vernon J., St. Louis
Rodes, Ned D., Mexico
Rodgers, Elrie P., Columbia
Rodgers, George H., Overland Park, Kan. (Member Jackson County Medical Society)
Rodgers, Samuel U., Kansas City
Rodrigo, Bernardo R., Jefferson City
Rodriguez, Gregorio L., Charleston
Rodriguez, Rolando A., Shawnee Mission, Kan. (Member Jackson County Medical Society)

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* Doctor of Osteopathy.

Rodriguez, Ubaldo R., St. Louis
Roehrs, Marvin E., Marshall
Rofail, Amin A., Shawnee Mission, Kan. (Member Jackson County Medical Society)
Rogers, Hunter Bryan, St. Louis
Rogers, John T., St. Joseph
Rogers, Robert L., Kansas City
Rogers, Wallace, Jr., Columbia
Roller, Merrill J., Hannibal
*Romito, Anthony, Kansas City
Roos, Albert, Kirkwood
Roper, Charles L., St. Louis
Roper, Stanley D., Ozark
Rose, Charles W., Kansas City
Rose, Dalton K., St. Louis
Rose, John F., Chillicothe
Rosecan, Marvin, St. Louis
*Rosell, Louis V., St. Louis
Rosenbaum, Harry D., St. Louis
Rosenbaum, Herbert E., St. Louis
Rosenfeld, Henry, St. Louis
Rosenholtz, Mitchell J., Columbia
Rosenstein, Daniel Lesem, Sikeston
Rosenthal, Irwin I., St. Joseph
Rosenthal, Randall, St. Louis
Ross, Gilbert, Jr., Columbia
Ross, William J., St. Louis
Rost, William B., St. Joseph
Roter, Alexander M., St. Charles
Roth, Alfred D., Kansas City
Roth, John J., Creve Coeur
Rother, Paul H., St. Charles
Rothman, David, St. Louis
Rothweiler, Robert J., St. Louis
Roufa, Joseph F., St. Louis
Roulhac, George E., St. Louis
Rouse, Ernest T., St. Louis
Roush, George, Jr., St. Louis
Roxas, Generoso P., St. Charles
Roy, Joseph A., Jennings
Royce, James J., Sarcoxie
Royce, Robert K., St. Louis
Royer, Jerry A., Columbia
Royse, Roy P., Sullivan
Royston, Grandison D., Little Rock, Ark. (Member St. Louis Medical Society)
Rozen, Jay I., Kansas City
Rubenstein, Melvin, St. Louis
Rubin, Harvey P., Kansas City
Rubin, Robert, St. Louis
Rubnitz, Leon H., Kansas City
Rudi, Herbert J., St. Louis
Rudman, Richard, St. Louis
Ruehl, Albert F., St. Louis
Rufe, John R., Kansas City
Ruff, T. Eugene, Poplar Bluff
Ruhling, Rudy, St. Louis
Runez, Manuel W., Cabool
Rusan, Thomas E., St. Louis
Russell, Barbara E., Rolla
Russell, Earl D., Springfield
Russell, Garth, Columbia
Russell, Herman E., St. Louis
Russell, James C., Kansas City
Russell, James L., Kansas City
Russell, Joseph P., Jefferson City
Russell, Robert K., Raytown
Rutledge, John F., Festus
Rutngamlug, Leucha, Florissant
Ryan, David L., Trenton
Ryan, John B., Washington
Ryan, John H., St. Joseph
Ryan, John J., St. Louis
Ryan, Robert E., St. Louis
Ryan, Thomas J., Jefferson City

S

St. John, Thomas C., St. Louis
Sabates, Felix N., Kansas City
Sachar, Leo A., St. Louis
Safdar, Shabbir, Granite City, Ill. (Member St. Louis Medical Society)
Saferstein, Lester, Kansas City
Saghir, Marcel, St. Louis
Saha, Nitai C., Ballwin
Saha, Sudha R., Ballwin
Saifee, Salma, St. Louis
Sala, Jose M., Springfield
Saladino, Anthony, Shawnee Mission, Kan. (Member Jackson County Medical Society)
Salanga, P. B., St. Louis
Sale, Llewellyn, Jr., St. Louis
Salmon, Mickey L., St. Louis
Sammon, T. James, Springfield
Sammons, Harry C., St. Louis
Samuelson. Edward A., Kansas City
Sanchez, Abelardo B., St. Louis
Sanchez, Salvador Valera, St. Joseph
Sanders, Donald C., Kansas City
Sanders, George E., Lees Summit
Sanders, Harmon U., Jr., Greenwood, Miss. (Member Jackson County Medical (Society)
Sanders, Jack S., Jefferson City
Sanders, Robert D., St. Louis
Sanders, Theodore E., St. Louis
Sanders, William F., Kausas City
Sandow, Theodore, Jr., Kansas City
Santillano, Antonio B., St. Louis
Santoro, Carlos G., Kansas City
Santos, Romeo I., Kennett
Santschi, Don R., Kansas City
Sanwardeker, Milind, Canton, Ohio (Member St. Louis Medical Society)
Sargent, Alden P., Sikeston
Sargent, John P., Sikeston
Sasser, William F., St. Louis
Sastry, Malladi R., St. Louis
Sato, George, St. Louis
Sauer, Donald C., St. Louis
Sauer, Gordon C., Kansas City
Sauer, Paul E., Springfield
Sauer, W. Nicholas, St. Louis
Saunders, Carol S., Columbia
Sauvage, Jacques, St. Louis
Savci, Hasan D., St. Louis
Sawyer, Floyd E., Kansas City
Sawyer, James, St. Louis
Scales, Margaret B.. Kansas City
Scanlon, Robert C., Springfield
Schaan, Robert C., St. Louis
Schaef, Mary L., St. Louis
Schaefer, George J., St. Louis
Schaefer, Glennon S., Jr., St. Louis
Schaeffer, Edward M., Springfield
Schaerer, Jacques P., St. Louis
Schaerrer, William C., Kansas City
Schaper, Ernest H., St. Louis
Schechter, Samuel E., St. Louis
Scheele, Paul M., St. Louis
Scheer, George E., St. Louis
Scheff, Harold, St. Louis
Scheibe, Robert G., St. Louis
Schengber, John S., St. Louis
Schertz, Truman B., N. Kansas City
Scheuber, Charles, Columbia
Schewe, Elmer J., Jr., Columbia
Schierman, William D., St. Louis
Schiffmacher, Jack E., Blue Springs (Member Jackson County Medical Society)
Schillie, Gene A., Kansas City
Schlansky, Seymour M., St. Louis
Schlozman, Daniel L., Kansas City
Schluer, Elmer P., St. Louis
Schmidt, C. Robert, Kansas City
Schmidt, Charles A., Gerald
Schmidt, Dennis A., St. Louis
Schmidt, Edwin H., St. Louis
Schmidt, Edmund M., St. Louis
Schmidt, Herbert J., Durham, N.C.; (Member Jasper County Medical Society)
Schmidt, J. H., Jefferson City
Schmiemeier, Roy H., St. Louis
Schneider, Sam, St. Louis
Schneider, Thomas A., St. Charles
Schober, Charles C., St. Louis
Schoeberl, Cletus B., Joplin
Schoeck, Albert F., St. Louis
Schoedinger, George R., III, St. Louis
Schoenberg, Harry W., St. Louis
Schoentag, John S., St. Louis
Schokker, Johannes, Jefferson City
Schonfeld, Gustav, St. Louis
Schoolman, Arnold, Kansas City
Schopp, Alvin C., St. Louis
Schottman, Gerhard W., Jr., Kansas City
Schranck, Charles R., St. Louis
Schreiber, Norman J., Springfield
Schroff, Carle H., Springfield
Schuessler, Wolfgang P., St. Louis
Schuetz, Alfred, St. Charles
Schulte, Gregory A., Joplin
Schultz, E. Robert, St. Louis
Schultz, Irwin, St. Louis
Schultz, Samuel, St. Louis
Schuman, Norvin D., Kansas City
Schutz, Carl B., San Marcos, Calif. (Member Jackson County Medical Society)
Schutz, John P., Excelsior Springs
Schutz, Richard B., Lee's Summit
Schwartz, Eugene J., Springfield
Schwartz, Frederick O., St. Louis
Schwartz, Henry G., St. Louis
Schwartz, Melvin M., St. Louis
Schwartzman, Bernard, Chesterfield
Schwarz, Luis, Clayton
Schweiss, John F., St. Louis
Sciortino, Gaspare, St. Louis
Sciortino, John S., St. Louis
Scopelite, Joseph A., St. Louis
Scorse, Sidney W., Joplin
Scott, E. David, Jefferson City
Scott, Elwin P., St. Louis
Scott, Horace W., St. Louis
Scott, John E., Independence
Scott, Kenneth F., Jr., Clinton
Seabaugh, Loy R., Cape Girardeau
Seabaugh, Ottis D., Webster Groves
Seabaugh, William O. L., Cape Girardeau
Seddon, John W., St. Louis
See, William B., Columbia
Seeley, James J., St. Louis
Seely, Clark W., Shawnee Mission, Kan. (Member Jackson County Medical Society)
Seevers. Ruth, Osceola
Sehra, K. H., St. Louis
Seib, George A., St. Louis
Seiden, Gerald D., Kansas City
Seitz, Elson F., Kansas City
Sells, Kenneth J., Kansas City
Sengupta, Dipak K., Archbald, Ohio (Member St. Louis Medical Society)
Senhauser, Donald A., Columbia
Senne, Herbert C., St. Joseph
Sennott, John S., Jefferson City
Senturia, Ben H., St. Louis
Senturia, Hyman R., St. Louis
Sermchief, Chaiyarat, Fredericktown
Sertl, George O., St. Louis
Sertl, James F., Ballwin
Sertl, John D., St. Louis
Sessions, Donald G., St. Louis
Sethabutra, Chaisiri, St. Louis
Sethabutra, Yolvilai, St. Louis
Sevastianos, Aristides E., St. Louis
Sexton, Daniel L., St. Louis
Sexton, Elmer E., St. Louis
Shackter, Bruce I., Springfield
Shah, Anwar, St. Louis
Shah, Bharat K., St. Louis
Shah, F. Naheed, St. Louis
Shah, Jitendra, St. Louis
Shahan, Philip T., St. Louis
Shaheen, Eleanor, Columbia
Shaikun, Gerald L., Chesterfield
Shalet, Malcolm F., Kansas City
Shalley, Jack E., Kansas City
Shanahan, Mary P., Joplin
Shanahan, Phil, J., Florissant
Shane, Ramon A., Springfield
Shaner, John F., St. Louis
*Shank, Neil A., Kansas City
Shank, Robert E., St. Louis
Shanks, William D., St. Louis
Shapiro, Herbert N., St. Louis
Shapiro, Lazare M., Kansas City
Shapleigh, John B., St. Louis
Sharp, Austin R., Ballwin
Shatz, Burton A., St. Louis
Shaw, Edward J., St. Louis
Shaw, William J., Jr., Fayette
Shea, James G., Washington
Sheahon, John A., Kansas City
Shechter, Nathan, Kansas City
Sheffield, William, St. Louis
Shelden, Russell D., Kansas City
Shell, William C., Sikeston
Shelton, Earl W., St. Louis
Shelton, Edward O., Eldon
Shelton, R. Wayne, Springfield
Shen, Jerome T. Y., St. Louis
Shen, Yen, Kansas City
Sheppard, Julius K., St. Joseph
Sheridan, Edmund R., St. Louis
Sheridan, John J., St. Louis
Sherman, Warren G., St. Louis
Sherwin, Charles S., St. Louis
Shevlin, Charles F., St. Joseph
Shieber, William, St. Louis
Shields, J. B., St. Louis
Shields, Lawrence S., Springfield
Shifrin, Alexander, Kansas City
Shintaku, Mickey, St. Louis
Shirey, Arnold G., Hayti
Shobe, Frank O., St. Louis
Shockley, Clarence J., Greenwood
Shoss, Milton, Cape Girardeau
Shreim, Ali R., Sikeston
Shriver, Ronald G., Poplar Bluff
Shuey, Herbert H., Kansas City
Shuff, Paul D., St. Louis
Shull, George D., Jefferson City
Shuman, Joseph S., St. Louis
Shumate, L. St. Clair, Reeds Spring
Shyken, Herman, St. Louis
Shypper, Moses J., Van Nuys, Calif. (Member Jackson County Medical Society)
Sicat, A. V., Warrensburg (Member Cole County Medical Society)
Siceluff, Joseph G., Springfield
Siegel, Carl D., Kansas City
Siemers, George E., St. Louis
Siesener, Herbert H., St. Louis

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* Doctor of Osteopathy.

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Sights, Warren P., Jr., Columbia
Sigmund, Charles A., St. Ann
Signorelli, Andrew J., St. Louis
Silliman, York E., St. Joseph
Silsby, Don J., Springfield
Silsby, Harry D., Springfield
Silva, Victor A., St. Louis
Silver, Bernd, St. Louis
Silverberg, Charles, St. Louis
Silverman, Barry, St. Louis
Silvermintz, Saul D., Ladue
Silvers, Robert G., Columbia
Simmons, Donald D., Kansas City
Simmons, John L., Kansas City
Simms, Otho M., St. Charles
Simon, David L., St. Louis
Simon, Jerome I., St. Louis
Simon, Nathan M., St. Louis
Simon, Sanford, Kansas City
Simonds, John F., Columbia
Simonian, Antonio, St. Charles
Simowitz, Fredric M., St. Charles
Simpson, Albert P., Springfield
Simpson, Emerson L., Springfield
Simril, Wayne A., St. Louis
Sims, William A., Jr., St. Louis
Sinclair, Richard H., Kansas City
Sincox, Charles H., Washington
Singhal, Gokul S., St. Louis
Singhal, Renu, St. Louis
Singleton, Chas. M., II, Kansas City
Singleton, John M., III, Kansas City
Singleton, Marvin A., Joplin
Sinsakul, Vichien, St. Louis
Sirintrapun, Seyvee, Festus
Siripipat, Pallop, Mexico
Sirridge, Marjorie S., Kansas City
Sirridge, William T., Kansas City
Sisk, James C., St. Louis
Sislen, Donald, St. Louis
Sisler, Maynard Lee, Kennett
Sisson, Richard G., St. Louis
Siu, Kenneth K. C., Jefferson City
Skeffington, Mary Jane, St. Louis
Skilling, David M., Jr., St. Louis
Skillman, Robert K., Shawnee Mission, Kan. (Member Jackson County Medical Society)
Skimming, W. Lee, Olivette
Skinner, John S., St. Louis
Skinner, John T., Kansas City
Sklenar, Donald E., St. Joseph
Slankard, J. Edward, Kansas City
Slaughter, Carl R., Kansas City
Slentz, Edwin L., Kansas City
Slentz, William A., Kansas City
Sletten, Ivan W., St. Louis
Slickman, Robert A., Kansas City
Sly, William S., St. Louis
Smiley, William, St. Louis
Smit, Herbert M., St. Louis
Smith, Arthur B., Kansas City
Smith, Benjamin F., Jr., St. Louis
Smith, C. Franklin, Willow Springs
Smith. C. Sonter, Springfield
*Smith, Charles H., Kansas City (Member Clay County Medical Society)
Smith, Dermott, St. Louis
Smith, Elbert E., III, Kansas City
Smith, Emily, St. Louis
Smith, Garland F., St. Louis
Smith, Herbert P., W. Palm Beach, Fla., (Member St. Louis Medical Society)
Smith, Hubert E., Kansas City
Smith, Hugh R., St. Louis
Smith, Ira T., Kansas City
Smith, J. Earl, St. Louis
Smith, James B., St. Louis
Smith, James M., Kansas City
Smith, James O., Clinton
Smith, Jason N., Jr., Columbia
Smith, Joe R., Columbia
Smith, John C., Kansas City
Smith, John R., St. Louis
Smith, Katherine W., Kansas City
Smith, Kathleen, St. Louis
Smith, Kenneth R., Jr., St. Louis
Smith, Morton E., St. Louis
Smith, Norris W., St. Louis
Smith, Othello D., Kansas City
Smith, Robert W., Brookfield
Smith, Roland T., Joplin
Smith, Rollin H., West Plains
Smith, Sidney E., St. Louis
Smith, Ted P., Rolla
Smith, Wallace B., Independence
Smith, William J., Windsor
Smith, W. Russell, Carthage
Smolik, Edmund A., St. Louis

Smoller, Martin B., St. Charles
Smull, Ned W., Kansas City
Snead, William H., Jr., Springfield
Sneid, Philip, Kansas City
Snider, Wilbur R., Kansas City
Snow, Emasue, Springfield
Snowe, Robert J., Sedalia
Sohn, Richard S., St. Louis
Soliman, Fawzi, St. Louis
Solley, Robert F., Old Saybrook, Conn. (Member St. Louis Medical Society)
Solomon, Felix G., St. Louis
Somers, John E., Columbia
Sommer, Conrad S., St. Louis
Sommer, Ross B., St. Louis
Somoza, Jose, Kansas City (Member Clay County Medical Society)
Soorya, Narendir T., St. Louis
Soper, Steven J., Independence
Soper, William D., Liberty
Sopuch, John A., St. Louis
Sosebee, Lee A., Columbia
Soto, Alberto A., St. Louis
Soucy, John C., St. Charles
Soule, Samuel D., Clayton
Spafford, Allen L., Kansas City
Spalding, David L., Springfield
Spalding, Donald G., St. Louis
Spalding, Wilber B., Plattsburg
Spalding, Wilber B., Jr., Kansas City
Sparkman, Thomas C., Cape Girardeau
Spears, Charles A., Branson
Spears, Joe L., Cabool
Spector, Gene W., St. Louis
Spector, Gershon J., St. Louis
Spence, Paul A., Cape Girardeau
Spencer, Donald M., Kansas City
Speno, Angelo A., St. Louis
Spies, Barbara J., Kansas City
Spinzig, Edgar W., Kirkwood
Spitz, Milton A., Chicago, Ill. (Member St. Louis County Medical Society)
Spitz, Richard H., St. Louis
Spivack, Alan R., St. Louis
Spoeneman, Marlin C., Chesterfield
Spoenemann, Walter H., St. Louis
Sponenberg, Don D., Springfield
Sportsman, Weldon L., Kansas City
Spratt, John S., Jr., Columbia
Sprinz, Helmuth, Kansas City
Spurgeon, Milo J., Columbia
Spurney, Joe E., Kansas City
Spurny, Otto M., Kansas City
Squitieri, A. J., St. Louis
Srikrishna, Sirivella, St. Louis
Srivisal, Somnuk, St. Louis
Stacey, Wallace R., Independence
Stacy, Winton T., St. Joseph
Stafford, Walter R., St. Louis
Staggs, William A., Kansas City
Staley, Harry R., Kansas City
Stallard, Donald J., St. Joseph
Stamatis, John J., Springfield
Stanczyk, Dennis J., St. Louis
Stanfield, Ned M., Jr., St. Louis
Stanley, John H., Kansas City
Stanley, Robert J., St. Louis
Staple, Tom W., St. Louis
Starkloff, Gene B., St. Louis
Starkloff, Max, St. Louis
Statland, Harry, Kansas City
Statland, Morris, Kansas City
Staton, R. Hamilton, Carrollton
Stauffacher, C. Gordon, Sedalia
Stauffer, Harry B., Jefferson City
Steele, Jack T., St. Louis
Steele, James C., Jr., Hannibal
Steffen, Lawrence F., Kansas City
Steffens, Richard S., Jr., Redding Calif., (Member Boone County Medical Society)
Stegman, Elmer G., Raytown
Stehr, Christian H., Springfield
Stein, Arthur H., Jr., St. Louis
Stein, Harry J., St. Louis
Steinbeck, Herbert D., Kingston, N. Y. (Member Franklin-Gasconade-Warren County Medical Society)
Steinberg, Franz U., St. Louis
Steiner, Alexander J., Clayton
Stelle, Charles W., Prairie Village, Kan. (Member Jackson County Medical Society)
Stelmach, Walter J., Kansas City
Stephen, C. Ronald, St. Louis
Stephens, Jack D., Kansas City
Stephens, LeRoy J., St. Louis
Stephens, William A., Chesterfield
Stephenson, Hugh E., Jr., Columbia
Stergen, Nick E., Florissant
Sterkel, Richard L., St. Louis
Sterling, John A., Kirkwood
Stern, Thomas L., Kansas City

Stevens, Edward M., St. Joseph
Stevens, Robert W., St. Louis
Stewart, Frances H., St. Louis
Stewart, Harry A., Kansas City
Stewart, John W., Ewing, Ill. (Member St. Louis Medical Society)
Stewart, Robert B., Springfield
Stewart, Robert H., Sedalia
Stewart, R. Wendell, Springfield
Stewart, Wellington B., Columbia
Stewart, Wendell K., Cape Girardeau
Stickle, Arthur W., St. Louis
Stickley, Louis P., St. Louis
Stindel, Charles E., St. Louis
Stockton, Raymond W., Kansas City
Stockwell, A. Lloyd, Kansas City
Stockwood, Robert C., Sedalia
Stohr, Paul E., St. Louis
Stokes, James M., St. Louis
Stolar, Jacob, St. Louis
Stoneman, William, III, St. Louis
Stotts, Charles S., Fredonia, Kan. (Member Jackson County Medical Society)
Stoy, Robert P., Columbia
Strader, Richard P., St. Louis
Stradford, H. Todd, Columbia
Stratemeier, Edward H., Kansas City
Stratman, Clarence A., Kansas City
Straub, David L., Joplin
Strauchen, Gilbert W. N., Key Largo, Fla. (Member St. Louis County Medical Society)
Strauss, Carl F., Kansas City
Streetor, Roderick D., St. Louis (Member Chariton-Macon-Monroe-Randolph County Medical Society)
Strehlman, Benjamin G., Union
Stribling, Thomas L., Independence
Stricker, Emil A., St. James
Stricker, Harold C., Jefferson City
Strobach, Kurt F., St. Louis
Strobach, Robert L., Butler
Stromberg, Eric D., Kansas City
Strominger. Donald B., St. Louis
Stronsky, David L., U. S. Naval Hospital, Guam (Member St. Louis Medical Society)
Stroud, Malcolm H., St. Louis
Struessel, Kenneth F., Columbia
Stryker, Garold V., Venice, Fla. (Member St. Louis Medical Society)
Stryker, William I., Ladue
Stuart, Byron M., Boonville
Stuart, Daniel D., Brunswick
Stuart, Wallace, St. Louis
Stubblefield, C. F., Poplar Bluff
Stubblefield, Wayne, Springfield
Stuber, Jack L., Kansas City
Stuber, Robert R., St. Joseph
Stuebner, Roland W., San Diego, Calif. (Member St. Louis County Medical Society)
Stuerman, Lawrence G., Louisiana
Stufflebam, Robert E., Springfield
Sturtevant, Harwood N., Springfield
Stutsman, Albert C., St. Louis
Suarez, Pedro L., St. Charles
Suba, Antonio R., St. Louis
Suddarth, Sterling B., Kansas City
Sudholt, Alfred F., Jr., St. Ann
Sugarbaker, Everett D., Jefferson City
Sullivan, Clement J., St. Louis
Sullivan, Dan T., Springfield
Sullivan, William K., Scott AFB, Ill. (Member St. Louis County Medical Society)
Sullivan, Wm. Wallace, Glencoe (Member St. Louis County Medical Society)
Sulzbach, John F., St. Louis
Sumathy, Vannarth, Kansas City
Sumer, Cengis M., St. Louis
Sumer, Emel A., St. Louis
Summers, John B., St. Louis
Summers, Joseph S., Jr., Jefferson City
Summers, Thomas F., St. Louis
Sundaram, Shankar, St. Louis
Sunderman, Raymond C., St. Louis
Sundstrom, Frank D., Springfield
Sunshine, Herbert, St. Louis
Susanka, William D., St. Louis
Suseela, Dasari, Kansas City
Susman, Irvin C., St. Louis
Susman, Noah, St. Louis
Sutter, Richard A., St. Louis
Sutton, Richard L., Jr., Shawnee Mission, Kan. (Member Jackson County Medical Society)
Sutton, Richard N., Wichita Falls, Tex. (Member Boone County Medical Society)
Suva, Morfeo M., Springfield
Swaykus, Bernard T., Bridgeton
Sweeney, Thomas P., Springfield
Sweet, Herbert C., Webster Groves

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* Doctor of Osteopathy.

Sweiger, James H., Plattsburg
Swisher, Robert C., Walnut Creek, Calif. (Member Jackson County Medical Society)
Switzer, Clyde, Overland Park, Kan. (Member Jackson County Medical Society)
Swope, Joseph A., St. Louis
Sword, Richard O., Kansas City
Sydow, Henry A., Fulton
Sylvanovich, W. Richard, St. Louis
Szabados, Ernest D., Independence
Szymanski, Stanley R., Macon (Member Grand River Medical Society)

T

Taglia, Santo W., St. Charles
Talaban, Raymundo D., Fredericktown (Member St. Louis County Medical Society)
Talbert, Clifford R., Jr., Cape Girardeau
Tamblyn, Claire L., Kansas City
Tan, Charles H., St. Louis
Tan, Sioe Sien, Farmington
Tanaka, George M., St. Louis
Tang, Theodoro C., Salem
Tanner, Robert H., Jefferson City
Tarrasch, Ernest L., Springfield
Tarson, Solomon S., Overland Park, Kan. (Member Jackson County Medical Society)
Tarver, Quinton, Kennett
Tarvydas, Francis, Edina
Tashma, Sigmund, St. Louis
Tasker, Charles B., Sun City, Ariz. (Member Jackson County Medical Society)
Tassi, Albert A., St. Charles
Tatkow, Robert W., St. Louis
Taussig, Barrett L., St. Louis
Taute, Herman, St. Louis
Tavassoli, Fataneh, St. Louis
Taylor, Eugene D., St. Louis
Taylor, Helen L., St. Louis
Taylor, Herbert B., St. Louis
Taylor, Leo T., Neosho
Taylor, Leon A., Jefferson City
Taylor, Loren F., Tucson, Ariz. (Member Jackson County Medical Society)
Taylor, Van W., Bonne Terre
Taylor, William E., Springfield
Tayob, Anver A., St. Louis
Teiber, Frederick W., St. Louis
Tejero, Jonas S., St. Charles
Tekwani, Hiralal, St. Louis
Temporal, Jose A., St. Louis
Tendai, Mark M., Springfield
Ternberg, Jessie L., St. Louis
Terry, Boyd E., Columbia
Terry, James F., Springfield
Terry, James W., Jr., Cape Girardeau
Tess, Allen F., Florissant
Tess, Melvin J. H., St. Louis
Tesson, James A., Shawnee Mission, Kan. (Member Jackson County Medical Society)
Thalblum, Harvey, Kansas City
Thale, Thomas, St. Louis
Thanapaisal, Vunnee, St. Louis
Tharp, Judith, Platte City
Theel, Otto W., Jr., Kansas City
Theobald, Sterling, Camdenton
Thiel, J. Allen, St. Louis
Thiele, Belmont R., St. Louis
Thiele, George H., Kansas City
Thiele, Otto K., St. Charles
Thierauf, Charles G., St. Louis
Thies, Jerome H., Osceola
Thind, Surinder S., St. Louis
Thoma, George E., Jr., St. Louis
Thomas, Christopher Y., Jr., Kansas City
Thomas, Fred A., Kansas City
Thomas, Gracy, St. Louis
Thomas, Horace E., Columbia
Thomas, Lewis J., Jr., St. Louis
Thomas, Robert M., Columbia
Thomas, Thomas C., Liberty
* Thomas-Richards, Jose R., Kansas City
Thomasson, David D., Springfield
Thompson, Charles L., Kansas City
Thompson, F. Gregg, III, St. Joseph
Thompson, Ian M., Columbia
Thompson, M. Bryant, St. Louis
Thomson, James Myron, Jr., Columbia
Thornton, Fred H., Sikeston
Throgmorton, Howard B., Sikeston
Throne, Bennie J., Kansas City
Throne, Elias M., Kansas City
Thurman, Hill C., Parkville
Thurmann, Manfred, St. Louis
Thym, Henry P., Ballwin
Tice, Wayne K., Independence
Tichenor, Robert W., St. Louis
Tietjen, Frederick O., Jefferson City
Tiffany, Delbert E., Poplar Bluff
Till, Bennie N., Poplar Bluff
Tillema, David A., Kansas City
Tillman, Mary A. T., St. Louis
Tillman, Walter W., Jr., Springfield
Tindall, Robert N., St. Louis
Tinsley, Austin R., Poplar Bluff
Tinsley, John C., Jr., Columbia
Tiojanco, Milagros E., Kansas City
Tiojanco, Reynaldo, Kansas City
Tiongson, Porfirio M., St. Louis
Tippett, Jack C., St. Louis
Titterington, Frank W., Kansas City
Tjoflat, Oliver E., St. Louis
Tobin, Robert F., St. Joseph
Tokrisna, Aphiraks, Independence
Tombridge, Thomas L., Springfield
Tomlinson, William L., St. Louis
Tompson, Robert V., Moberly
Tonelli, George L., St. Louis
*Toon, Thomas J., St. Louis
Torin, Bernice A., University City
Torontow, John, Nevada
Totten, Frederick E., Overland Park, Kan. (Member Jackson County Medical Society)
Toubes, Daniel B., Kansas City
Towers, Orville W., St. Charles
Traxel, William Louis, Poplar Bluff
Treiman, Robert C., St. Louis
Trimble, David P., Jr., Excelsior Springs
Trimble, George X., Kansas City
Trinidad, Hermanito R., Chillicothe
Triplett, Daniel A., Kansas City
Triska, Roland A., St. Louis
Troeh, Melvin R., Independence
Trotter, Francis O., Jr., St. Louis
Trotter, W. Yates, Springfield
Trowbridge, Barnard C., Kansas City
Trowbridge, Ellsworth H., Jr., Kansas City
Trueblood, Alva C., Jr., St. Louis
Trugly, Edith S., St. Louis
Trumbower, William D., Columbia
Trunko, Leo, St. Louis
Tsang, John L. K., Springfield
Tsifutis, Argyrios, St. Ann
Tucker, Eugene F., St. Louis
Tucker, George L., St. Louis
Tuma, Arthur T., Poplar Bluff
Tumanut, Benesto F., Kansas City (Member Clay County Medical Society)
Tumialan, Luis, St. Louis
Tuohy, Gerald F., Kansas City
Turano, William L., Kansas City
Turati, Gianfranco, St. Louis
Turgeon, Ronald P., St. Louis
Turner, C. M., St. Louis
Turner, Glenn O., Springfield
Turner, James H., Poplar Bluff
Turner, James K., St. Louis
Turner, Kirby L., Poplar Bluff
Turner, Ronald M., Independence
Turner, William F., Poplar Bluff
Tutera, Dominic F., Kansas City
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Tuthill, Herbert, Barrington, Ill. (Member Jackson County Medical Society)
Tuttle, Jay F., Farmington
Twedell, Donald L., St. Louis
Twin, Edward J., Kansas City
Twyman, Richard A., Kansas City
Tygett, Glenn J., Cape Girardeau
Tygett, Joseph N., Cape Girardeau

U

Uhlemeyer, Henry A., St. Louis
Ulett, George A., St. Louis
Ulett, Pearl C., St. Louis
Umali, Emil C., St. Louis
Underwood, Dick H., Kansas City
Underwood, Johnson, III, Kansas City (Member Clay County Medical Society)
Ungvari, Joseph C., St. Louis
Upsher, Albert E., Kansas City
Urban, Edgar D., Sikeston
Utley, James H., St. Louis
Utterman, William F., Ste. Genevieve

V

Vacca, Joseph B., St. Louis
Vafi, Houshang, St. Charles
Vajaranant, Manit, Lexington
Valach, Frank J., St. Louis
Valdes, Orestes S., St. Louis
Valins, Eugene, Kansas City
Valko, Robert J., St. Louis
Valtierra, Cesar A., St. Louis
Van Biber, James T., Independence
Van Buskirk, Terrance E., Kansas City
Van Buskirk, William C., Kansas City
Van Dervoort, Robert L., Jr., Columbia
Vandiver, Virgil D., Chillicothe
Vandover, John T., St. Louis
Van Dyke, Elmer H., Sedalia
VanGoidsenhoven, Guy, St. Louis
Van Hook, David M., Kansas City
Van Matre, R. M., Washington, D. C. (Member St. Louis Medical Society)
Van Norman, Robert T., St. Louis
Van Thullenar, Philip A., Kansas City
Van Vranken, Eugene E., Jefferson City
Vardeleon, Roger V., St. Louis
Vargas, Teodoro C., Ballwin
Varma, D. K., Poplar Bluff
Vart, Gary R., St. Charles
Vatterott, Paul B., St. Ann
Vaughan, J. Russell, St. Louis
Vaughan, Robert W., St. Louis
Vaughn, James W., Kansas City
Vaughn, Leroy W., St. Louis
Velasco, Ernest, St. Louis
Veluz, Benito I., St. Louis
Venegoni, Robert L., Kansas City
Vensel, Lee H., Springfield
Ventus, Manuel A., Chesterfield
Vera, Enrique, Kansas City
Verda, Dominic J., St. Louis
Verde, Julian N., St. Louis
Vergara, Gerardo G., Shawnee Mission, Kan (Member Jackson County Medical Society)
Verzola, Eufemio, Festus
Vescovo, Paul C., Jr., Kansas City (Member Platte County Medical Society)
Vest, James C., St. Louis
Viamontes, Jorge A., St. Louis
Vianzon, Elizabeth, St. Louis
Vibulakaopun, Pairat, Bonne Terre
Victor, Frank R., Kansas City
Vidals, Victor G., Kansas City
Vidheecharoen, S., Florissant
Viers, Wayne A., St. Louis
Vighi, James R., St. Charles
Vigor, William, Wheatridge, Colo. (Member St. Louis Medical Society)
Vijungco, Herminia D., Chesterfield
Vilar, Pio M., Jr., Chesterfield
Villadiego, Virgilio, St. Louis
Villahermosa, Juanito L., Savannah
Villamar, Elizabeth N., St. Louis
Villanueva, Angela A., Prairie Village, Kan. (Member St. Louis Medical Society)
Villarama, Antonio P., Ballwin
Villarama, Lilia F., Manchester
Vilmer, Charles, N. Kansas City
Viloria, Alberto B., St. Louis
Vincent, Jack C., Kansas City
Vinson, Harold A., Tulsa, Okla. (Member Jasper County Medical Society)
Vinyard, Jack L., Joplin
Viraghaty, Julius G., Glencoe
Virant, John A., St. Louis
Virden, Herbert, Kansas City
Viril, Leonardo C., Kansas City
Vitale, Anthony J., St. Louis
Vitale, Nicholas S., St. Louis
Vitt, Alvin E., Wright City
Vitt, Edwin F., St. Louis
Viviano, Joseph G., St. Louis
Vogel, Arthur P., Shawnee Mission, Kan., (Member Jackson County Medical Society)
Volk, George E., Kansas City
Vollmar, Clarence J., St. Louis
Votaw, Robert E., St. Louis
Voth, Harold W., Kansas City
Vournas, Christopher G., St. Louis

W

Wacker, Leo L., St. Louis
Waddell, Kenneth E., Springfield
Waddle, Theodore L., Dexter
Wade, Frederick E., Kansas City
Wade, James P., St. Louis
Wadlow, Ernest E., St. Joseph
Wagan, Primitiva C., St. Louis
Waggoner, Charles M., Columbia
Waggoner, Sharon E., St. Joseph
Wagner, John R., St. Louis
Wagner, Paul J., Kansas City
Wakefield, Franklin H., Sun City, Ariz. (Member Jackson County Medical Society)
Wakeman, Jasper N., Springfield
Wakeman, Jasper Newton, Jr., Springfield
Wakerlin, G. E., San Francisco, Calif. (Member Boone County Medical Society)
Wald, Donald M., North Kansas City
Wald, Stanley M., St. Louis
Waldman, Richard A., Kansas City
Walker, Ambrose T., Thayer
Walker, Francis S., St. Louis
Walker, Harvey, Jr., St. Louis
Walker, J. Leslie, St. Louis
Walker, James C., Kansas City
Walker, John W., Kansas City

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* Doctor of Osteopathy.

Walker, Larry G., St. Joseph
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Walker, Willard B., Clayton
Walker, William M., Springfield
Wall, Harry C., Kansas City
Wall, Joe A., Houston
Wall, Leonard A., Kansas City
Wall, Lester E., Kirkwood
Wallace, Edgar S., Mexico
Wallace, Hilen K., St. Joseph
Wallace, John K., II, Jefferson City
Wally, John W., Kansas City
Walsh, James W., St. Louis
Walter, Archie L., Sedalia
Walter, Kenneth E., St. Louis
Walter, William L., St. Louis
Walters, Harold E., St. Louis
Walters, Henry W., St. Louis
Walters, John H., Columbia
Walters, Laura. Columbia
Walterscheid, John H., Hannibal
Walther, Roy A., Jr., Ballwin
Waltman, Stephen, St. Louis
Walton, Franklin E., St. Louis
Waltrip, Roy T., Jr., Sikeston
Waltz, Charles A., Kansas City
Waltz, James R., Kansas City
Walz, Bruce J., St. Louis
Wanamaker, John M., Rock Port
° Wang, George Y. M., Belton (Member Jackson County Medical Society)
Wang, Hubert K. W., St. Joseph
Wantuck, Donald K., Springfield
Ward, Joe, Lexington
Ward, Robert L., St. Louis
Warren, James C., St. Louis
Warren, William H., Springfield
Warres, Herbert L., Springfield
Washburn, J. Loren, Versailles
Washington, Edward L., Columbia
Washington, Walter, St. Louis
° Wasserman, Gary S., Kansas City
Wasserman, Helman C., St. Louis
Waterfield, Jim R., Springfield
Waterman, Franklin M., Liberty
Waters, Hugh R., St. Louis
Wathanacharoen, Suchint, Kansas City
Watkins, Garey L., St. Louis
Watkins, George L., Jr., La Jolla, Calif. (Member Mineral Area County Medical Society)
Watson, Ethel, Independence
Watson, Trevor F., Columbia
Wattenberg, Carl A., St. Louis
Watts, Byron E., Jefferson City
Waxelman, Roger J., Manchester
Waxman, Herbert J., Kansas City
Waxman, Jane Z., Kansas City
Wayland, Thomas A., Camdenton
Wayne, Sherwyn J., Kirkwood
Webb, Harry E., Kansas City
Webb, Leslie R., Jr., Springfield
Webb, Marion A., Clayton
Webb, Paul B., St. Louis
Webb, Paul B., Jr., St. Louis
Webb, Paul K., St. Louis
Webber, Wm. B., St. Louis
Weber, J. R., St. Louis
Weber, Sol, St. Louis
Wee, Eng Chuan T., St. Louis
Wee, George C., Ellisville
Weed, Randal W., St. Joseph
Weeks, George R., Cape Girardeau
Weeks, Paul M., St. Louis
Weide, Allan R., Kansas City (Member Clay County Medical Society)
Weidmaier, Edward J., Kansas City
Weiford, Edward C., Kansas City
Weigel, James W., Columbia
Weiler, Thomas J., St. Louis
Weinand, Ernest E., St. Joseph
Weinhaus, Robert S., St. Louis
Weir, Don C., St. Louis
Weir, Robert K., Kansas City
Weir, Royal A., Ballwin
Weis, Matthew W., Villa Ridge
Weisman, Renate D., St. Ann
Weiss, James M. A., Columbia
Weiss, Stuart, St. Louis
Weldon, Clarence S., St. Louis
Well, Julius W., Palmyra
Wells, Donald E., Kansas City
Wells, James A., Kansas City
Wells, John H., Kansas City
Welner, Amos, St. Louis
Welner, Zila, St. Louis
Welsh, Laurence C., St. Louis
Wempe, G. Raymond, Maryville
Wenneker, Alvin S., St. Louis
Wenner, Herbert A., Kansas City
Wentzel, Louis R., St. Louis
Werner, Dean F., N. Kansas City (Member Clay County Medical Society)
Werner, Franklin C., Kansas City
Werner, William A., St. Louis
Werth, Joseph, Jefferson City
Wessler, Stanford, St. Louis
West, Harold D., Kansas City
West, Joseph W., St. Louis
Westerfeld, Roy A., St. Charles
Westerman, Henry C., University City
Westerman, Robert N., St. Louis
Westhoff, D. Douglas, Jefferson City
Westrup, Ellsworth A., Webster Groves
Wetzel, Gus S., Clinton
Weyerich, Leon F., St. Louis
Weyerich, Noel F., Chesterfield
Weygandt, Glenn R., St. Louis
Wheeler, Charles B., Kansas City
Wheeler, John H., Kansas City
Wheeler, Robert L., Harrisonville
Whitaker. Topsy H., East Prairie
White, Barry B., Poplar Bluff
White. Bruce I., St. Louis
White, Charles H., Kansas City
White, Eugene F., Rolla
White, James S., Kansas City
White, Joseph, Columbia
White, Newton B., St. Louis
White, R. Ned., Springfield
White, Stoughton F., Kansas City
White, William E., Kansas City
White, William H., Jr., St. Louis
Whiteman, John R., Kansas City
Whitener, Miles C., St. Louis
Whitener, Paul R., St. Ann
Whitlock, C. Courtney, Springfield
Whitman, Doyle C., Shawnee Mission, Kan. (Member Jackson County Medical Society)
Whitmore, J. Stewart, Kansas City
Whitsell, Ora E., St. Joseph
Whittaker, Charles K., Kansas City
Whitten, John S., Independence
Whitten, Marion F., Carthage
Whittico, James M., St. Louis
Wiant, James R., St. Louis
Wichienkuer, P., St. Louis
Wicks, Edwin O., Kansas City
Wiedershine, Leonard J., St. Louis
Wiegand, Herbert C., St. Louis
Wieman, Harry K., Joplin
Wien, Irving A., Kansas City
Wiggins, Roland L., Columbia
Wilber, Robert D., Kansas City
Wilbers, Raymond H., Mexico
Wilbois, Ronald P., St. Louis
Wilcox, Ruth E., Joplin
Wilcoxen, William B., Bowling Green
Wiles, Jack N., West Plains
Wilhelm, K. G., Columbia
Wilhelm, Warren F., Kansas City
Wilkinson, Charles B., Kansas City
Wilkinson, Everett A., Kansas City
Willcox, Roger, Branson
Willcoxon, Robert L., Joplin
Williams, Andrew F., Columbia
Williams, Carol F., St. Louis
Williams, Frank R., Kansas City
Williams, George P., Kansas City
Williams, Jerome, St. Louis
Williams, John M., Liberty
Williams, John W., Oak Grove
Williams, John W., Springfield
Williams, Joseph C., Jr., Kansas City
Williams, Paul A., Fulton
Williams, Ray D., St. Louis
Williams, Robert D., Kansas City
Williams, Robert S., Mexico
Williams, Roland D., Kansas City
Williams, Starks J., Kansas City
Williams, Thomas A., Leawood, Kan. (Member Jackson County Medical Society)
Williams, Walter R., St. Louis
Williamson, George L., N. Kansas City (Member Clay County Medical Society)
Williamson, Walter E., St. Louis
Willis, H. Robert, St. Louis
Willman, Charles R., St. Joseph
Willman, Martin L., St. Louis
Willman, Vallee L., St. Louis
Willoughby, James W., Kansas City
Willoughby, Jean B., Kansas City
Willumsen, Henry C., St. Joseph
°Wilson, A. W., St. Louis
Wilson, Alice H., Neosho (Member Jasper County Medical Society)
Wilson, Charles F., Cape Girardeau
Wilson, Clifford C., Kansas City
Wilson, David E., Kansas City (Member Clay County Medical Society)
Wilson, Fred K., Winston
Wilson, George P., Columbia
Wilson, Hugh M., St. Louis
Wilson, John E., Columbia
Wilson, Keith S., Clayton
Wilson, Loys C., Kennett
Wilson, Roy E., Springfield
Wilson, Susan L., St. Louis
Wilucki, Melvin R., St. Louis
Wimmer, Warren J., St. Louis
Windmiller, Myrl E., Columbia
Windsor, Charles E., St. Louis
Windsor, David G., Savannah (Member Buchanan County Medical Society)
Winegar, Alvon C., Jefferson City
Winer, Herbert J., Kansas City
Winer, Michael H., St. Louis
Winer, Nathaniel, Kansas City
Winkelman, Esther B., Kansas City
Winn, George W., Boonville
Winsky, Arlen D., Springfield
Winston, Bernard H., Kansas City
Winter, John H., St. Louis
Winter, Tyrus D., St. Louis
Winterer, Roland A.. St. Louis
Winters, Kathleen, St. Louis
Wipfler, Earl J., Jr., St. Charles
Wirth, Fremont P., St. Louis
Wirthlin, Edward H., St. Louis
Wise, George W., Kansas City
Wise, Gordon F., Springfield
Wise, Leslie, St. Louis
Wise, Morris F., Kansas City
Wissmath, Frank S., Clayton
Wissner, Seth, St. Louis
Withers, Orval R., Kansas City
Withrow, John B., N. Kansas City (Member Clay County Medical Society)
Witt, Clyde M., St. Louis
Witt, Frederick W., St. Louis
Wittgen, Edward M., St. Louis
Wittler, Harry A., St. Louis
Wittmer, Samuel C., Springfield
Wochner, R. Dean, St. Louis
Woehl, Joseph J., Kansas City
Wolf, David I., Florissant
Wolf, Jack W., Kansas City
Wolf, Mitchel L., St. Louis
Wolfe, Edward, St. Louis
Wolff, Dolores P., St. Louis
Wolff, Gerald, St. Louis
Wolff, Harold D., St. Louis
Wolff, Paul G., Cape Girardeau
Wolff, Ray J., St. Ann
Wolfgram, Edwin D., St. Louis
Wolfram, Philip H., Smithville (Member Platte County Medical Society)
Wommack, Fred L., Crane
Wong, George, Jr., Springfield
Wood, Bennett R., St. Louis
Wood, George F., Fulton
Wood, George H., Carthage
Wood, James A., Clayton
Wood, Tom, Poplar Bluff
Wood, William W., West Plains
Woodman, Grey M., Kansas City
Woodruff, Calvin W., Columbia
Woodruff, Robert A., Jr., St. Louis
Woodruff, Sharon, Washington (Member St. Louis County Medical Society)
Woods, Harold V., Blue Springs
Woods, Ralph E., Clayton
Woods, S. Dwight, Kansas City
Woods, Walton C., Kansas City
Woodward, William W., Kansas City
Wool, Gerald, St. Louis
Wooldridge, Wilfred E., Springfield
Woolsey, Joyce E., St. Louis
Woolsey, Robert M., St. Louis
Word, Parker H., St. Louis
Workman, Charles E., N. Kansas City (Member Clay County Medical Society)
Workman, George M., Hermann
Worley, Charles A., Sweet Springs (Member Pettis County Medical Society)
Wortmann, Robert F., Kansas City
Wotawa, William J., St. Louis
Wray, Rolla B., Nevada
Wray, R. C., Jr., St. Louis
Wright, Earl J., Kansas City
Wright, Robert P., Kansas City
Wu, Shuh-Min, Kansas City
Wu, William Q., Kansas City
Wulff, George J. L., Jr., St. Louis
Wurr, Dieter, Arnold
Wurster, Jerry B., Kansas City
Wurster, W. Joel, Kansas City
Wyatt, Lois C., St. Louis
Wyrsch, Leo M., Jr., Springfield

Y

Yaeger, Gerald A., St. Charles
Yalcin, Enver, St. Louis
Yancey, Daniel L., Springfield

° Doctor of Osteopathy.

Yannakakis, John E., Florissant
Yanow, Mitchell, St. Louis
Yap, Mardonio J. R., St. Louis
Yasin, Fazle Mobin, St. Louis
Yates, Darrel W., St. Louis
Yazdi, A. M., St. Louis
Yeager, Helen, Columbia
Ylagan, Amando, Jr., St. Louis
Yoon, Jin Soo, Chillicothe
Yore, Richard W., St. Louis
Yoskit, Harry, Festus
Youll, Donald V., Kansas City
Youmans, Ronald A., Kansas City
Young, Calvin C., Jr., Joplin
Young, James E., Kansas City
Young, Jesse W., Kansas City, Kansas (Member Jackson County Medical Society)
Young, Paul R., Columbia
Young, Robert B., Rolla
Young, Thomas J., St. Joseph
Youngblood, James P., Kansas City
Younge, Walter A., Lovejoy, Ill. (Member St. Louis Medical Society)
Younger, Anita, St. Louis
Younger, Ernest, St. Louis

Z

Zacharias, David L., Kansas City
Zacharias, K. P., St. Louis
Zahn, Robert L., Springfield
Zahony, Ivan, Prairie Village, Kan. (Member Jackson County Medical Society)
Zahorsky, Carroll L., Kansas City
Zahorsky, Theodore S., St. Louis
Zeffren, Joel L., St. Louis
Zeigler, Joseph M., Creve Coeur
Zekert, Horst, St. Louis
Zellermayer, Jacob, Shawnee Mission, Kan. (Member Jackson County Medical Society)
Ziegelmeyer, John S., St. Louis
Zimmerman, Herbert B., St. Louis
Zimmerman, Joseph A., Kennett
Zingale, Frank G., St. Louis
Zink, Oscar C., St. Louis
Zinn, Marsha V. E., Kansas City
Zivnuska, Fred R., St. Louis
Zografakis, George H., St. Louis
Zoller, David D., Kansas City
Zuckner, Jack, St. Louis
Zukowski, Edward T., Chesterfield
Zwart, Claude H., St. Louis
Zwerenz, Bruno H., Kansas City
Zwirn, Benjamin H., Florissant

For Your Convenience—

New Members . . . Address Changes . . . Notes

This space is provided for your convenience in recording names and addresses of new members of your county society, address changes of members you know and other notations you may wish to make.

Roster of Members by County Societies

(See Instructions on Page 403)

ADAIR COUNTY
(North Central Counties Medical Society)

ANDREW COUNTY MEDICAL SOCIETY
(Savannah 64485)

Baker, Warren C., Savannah
Kelley, Gilbert B., Savannah
Villahermosa, Juanito L., Savannah

ATCHISON COUNTY
(Northwest Missouri Medical Society)

AUDRAIN COUNTY MEDICAL SOCIETY
(Mexico 65265)

Ajans, Z. A., 704 E. Monroe
Boyce, John M., 620 E. Monroe St.
Bradley, William W., Box 47, Centralia 65240
Comfort, George D., 1415 S. Morris
Cottey, John H., 217 E. Jackson
Daut, Donald W., 200 East Monroe
Davis, Leonard L., Jr., #5 Melody Lane
Dwyer, Thomas L., 119 E. Love St.
Ector, Henry J., 521 E. Breckenridge
Ekern, H. Peter, 1415 S. Morris St.
Garcia, Charles L., Mexico
Hoxworth, Gerald, 415 E. Monroe
Huq, Md. Nasrul, 212 E. Monroe
Jolly, Benjamin N., 112 N. Clark Ave.
Jolly, William H., 112 N. Clark Ave.
Kallenbach, Glen P., P. O. Box 249
Lankford, Harold D., 117 E. Monroe St.
O'Brien, Harry F., Mexico
Reddin, Patrick, Wallmart Bldg.
Rodes, Ned D., Mexico
Siripipat, Pallop, 222 E. Monroe
Wallace, Edgar S., P. O. Box 471
Wilbers, Raymond H., 113 E. Monroe
Williams, Robert S., P. O. Box 147

BARRY COUNTY
(Ozarks Medical Society)

BARTON COUNTY MEDICAL SOCIETY
(Lamar 64759)

Arnold, Herbert M., Lamar
Bickel, Vern T., 202 West 2nd
Cain, Alvin R., Lamar
Carroll, Thomas W., P.O. Box 368
Guldner, Edmond, 1103 Broadway

BATES COUNTY
(West Central Missouri Medical Society)

BOLLINGER COUNTY
(Mineral Area Medical Society)

BOONE COUNTY MEDICAL SOCIETY
(Columbia 65201)

Abadir, Rushdy, 807 Stadium
Adams, Harold D., 401 Keene
Allcorn, Donald J., 807 Stadium
Allen, Joseph E., 5813 St. Charles Rd.
Allen, Robert W., 2007 S. Country Club Dr.
Allen, William C., 508 W. Briarwood Lane
Almond, Carl H., 807 Stadium Rd.
Anderson, Ivan A., 606 Medavista
Anderson, Philip C., 807 Stadium Rd.
Anderson, Thomas R., Strollway Center
Arnold, Richard C., P. O. Box 53
Asel, Norman D., 1502 E. Broadway
Aylward, Howard J., Jr., 807 Stadium
Baker, A. Sherwood, 807 Stadium Rd.
Baker, James M., 16 S. 10th St.
Barbee, Charles W., 401 Keene St.
Barbero, Gilulio J., 807 Stadium
Barnes, Asa, Jr., Ellis Fischel Cancer Hosp.
Black, Samuel P. W., 300 S. Glenwood St.
Blackwell, Charles W., 201 W. Broadway
Bourgeois, Curtis, P.O. Box 118, Rocheport 65279
Brubaker, Leonard L., 807 Stadium
Brukardt, Diane, Student Health Service
Bruner, Claude R., Star Rt. B, Box 5-HD, Camdenton 65020
Bumgarner, James E., 1504 E. Broadway
Bumgarner, Roger W., P. O. Box 975
Burns, Thomas W., 310 E. Brandon Rd.
Butt, James H., 800 Stadium
Byer, John A., 807 Stadium
Bynum, William R., P. O. Box 998
Callen, Kenneth E., 807 Stadium
Carnahan, Charles E., 3801 Cedar Lane
Carolla, Robert L., 807 Stadium
Chalkley, Judson I., Boone County Hosp.
Chapel, James L., 807 Stadium
Chapman, Charles L., 1916 Ridgemont
Cheek, Charles W., 3205 Lansing Dr.
Chiasson, E. Chaille, P. O. Box 1077
Cochran, Donald Q., 1502 E. Broadway
Cohen, Harry B., 807 Stadium
Colwill, Jack M., Countryshire, R.F.D. 5
Cooper, Maurice E., 1000 Wayne Rd.
Cope, James C., 1502 E. Broadway
Craig, Herbert W., 807 Stadium
Crowley, Wm. J., Jr., 11 S. Williams
Culley, Thomas S., 807 Stadium Rd.
Darnell, Thomas F. B., Doctors Clinic Bldg.
Davis, David, 801 Crestland Ave.
Davis, William E., 807 Stadium
DeLima, Clarence A., 803 Stadium
Denninghoff, James C., 201 W. Broadway
Dexheimer, Frank R., 401 Keene
Dexter, James D., 807 Stadium Rd.
Dickhaus, Donald, 807 Stadium
Donegan, Judith H., University of Missouri Medical Center
Donegan, William L., Ellis Fischel Cancer Hosp.
Eggers, George W. N., Jr., 807 Stadium Rd.
Esterly, James A., 807 Stadium
Farrell, Corinne, 807 Stadium
Favazza, Armando R., 807 Stadium
Ferneau, James E., 401 Keene
Foote, Jerry E., 1504 E. Broadway
Frazier, Robert Edward, 113 W. Broadway
Fried, Frederick E., 807 Stadium
Fristoe, Frank, Jr., 807 Stadium
Frueh, Bartley R., 108 Park Hill Ave.
Fuchs, George J., Jr., 1504 E. Broadway
Galeota, William R., 807 Stadium Rd.
Gambill, Alice F., 807 Stadium
Gammel, George E., Boone County Hospital Laboratory
Garrett, Glen H., 909 University Ave.
Garrotto, Lewis J., 814 Hulen Dr.
Gaunt, William D., 807 Stadium Rd.
Godshalk, M. Fredrica, 807 Stadium
Gohil, Jivanlal P., 803 Stadium
Gordon, Bruce J., 807 Stadium
Griffin, William T., 807 Stadium Rd.
Hall, David G., 807 Stadium Rd.
Hardwicke, Henry M., Ashland 65010
Harris, Hugh S., Jr., 801 Cowan Dr.
Harris, Robert J., 2505 E. Broadway
Harrison, Winston E., 201 W. Broadway
Hart, William M., 807 Stadium Rd.
Haw, Marvin T., Jr., 1807 Jackson
Hawkins, James C., 806 Stadium
Heimburger, Elizabeth M., M-330, 807 Stadium
Heimburger, Richard A., M-349, 807 Stadium
Henry, Lawrence D., P.O. Box 998, 2703 Clark, La.
Henzel, John H., N-303, 807 Stadium
Hickcox, John P., 3205 Lansing Ave.
Hofmeister, Roger W., 807 Stadium
Hori, Jose M., Community Memorial Hosp., Moberly 65270
Hubbell, Ira G., 302 McNab Dr.
Husain, Syed A., 807 Stadium
Hyatt, Robert W., 4650 Sunset Blvd., Los Angeles, Calif. 90054
Ide, Carl H., 600 Laurel Dr.
Jackson, Robert L., 807 Stadium Rd.
James, Elizabeth J. P., 807 Stadium Rd.
James, Ronald C., 610 W. Blvd. South
Johnsgard, Larry S., 807 Stadium Rd.
Johnson, Richard E., Boone County Hosp.
Joseph, Donald J., 807 Stadium Rd.
Kamal, Waseem, 807 Stadium
Kaplan, Michael F., 1409 Overhill Rd.
Kardinal, Carl G., Business Loop 70 & Garth
Kays, Kenneth, 1502 E. Broadway
Ketizer, Walter Ford, 807 Stadium
Keown, Kenneth K., 807 Stadium Rd.
Kerr, S. Earl, 1308 Fieldcrest
Kilburn, Kaye H., VA Hospital, Rm. 570
Kim, Tchang Man, 3315 E. 76th, Tulsa, Okla. 74125
King, Robert J., 1502 E. Broadway
Kubin, Milford T., 541 Seventeen Mile Dr., Pacific Grove, Calif. 93950
LaChance, Leopold, 110 W. Sneed, Centralia 65240
Ladenson, Roland P., 16 S. 10th St.
Lamberti, Joseph, 807 Stadium
Landhuis, L. R., 3205 Lansing Dr.
Lee, Sung Ae, 3315 E. 76th, Tulsa, Okla. 74125
Leech, Charles A., 1504 E. Broadway
Leeper, Claude K., 807 Stadium
Leeper, Sidlee W., 1504 E. Broadway
Lehr, James L., 807 Stadium Rd.
Lillard, Stephen B., 807 Stadium
Lim, Jit Kim, 807 Stadium
Lindberg, Donald, Route 4
Litton, Lynn O., 3205 Lansing Ave.
Litwiller, R. W., 1312 W. Broadway
Lodwick, Gwilym S., 911 La Grange
Logue, John T., 1504 E. Broadway
Lohmar, Roland E., 113 W. Broadway
Lucas, Fred V., 807 Stadium Rd.
McClelland, Bruce A., 807 Stadium
McCluer, Shirley, McHaney Hall, 807 Stadium
McCord, E. Scott, 807 Stadium Rd.
McElroy, Glenn L., 3205 Lansing Ave.
Marco, Philip J., 1015 College Park
Marienfeld, Carl J., 807 Stadium Rd.
Mayer, William D., 1 Ridgeley Rd.
Meyers, David S., 807 Stadium
Miller, Leroy J., 1502 E. Broadway
Millikan, Larry E., 807 Stadium Rd.
Mitchell, Franklin L., 2208 Danforth Ct.
Mitchell, Lynn D., 401 Keene
Monroe, C. Dean, 803 Stadium Rd.
Montie, Joseph E., 807 Stadium
Moranville, Benedict A., 1504 E. Broadway
Morgan, Philip E., N-320, M. U. Medical Center, 807 Stadium
Mosby, Larry D., 107 E. Brandon Rd.
Mullins, Maurice F., 217 W. Broadway
Mussell, Howard L., 807 Stadium, M-343
Navarro, Manuel I., 807 Stadium
Nichols, W. Kirt, 807 Stadium
Nieuwenhuizen, Maarten, 803 Stadium Rd.
Nolph, Georgia B., 801 Westport Dr.
Oestreich, Alan, N217 University Medical Center
Orth, Oliver G., 11 S. Williams
Overholser, Milton D., 807 Stadium Rd.
Payne, David E., 1901 Ridgemont
Payne, John W., 3205 Lansing Ave.
Pearman, Carl C., Box 354
Perez-Mesa, Carlos, Ellis Fischel State Cancer Hosp.
Peterson, Charles R., 301 McHaney
Peterson, Vernon J., 4730 Brentwood, Topeka, Kan. 66603
Pfefer, Leland U., 1504 E. Broadway
Pickard, Clarence M., 113 W. Broadway
Pickens, James Milton, 807 Stadium
Pingelton, William B., 113 W. Broadway
Politte, Lenard L., 401 Keene
Prendergast, Thomas J., Jr., 807 Stadium
Pugh, Reginald P., 320 E. North Ave., Allegheny General Hospital, Pittsburgh, Pa. 15212
Rall, Kenneth L., 1121 Danforth Dr.
Ridenhour, C. E. Gene, Rt. 1, Cedar Grove Estates
Rikli, Arthur E., 4003 Faurot Dr.
Rink, Richard A., E-307, Stadium Rd.
Rodgers, Elrie P., Box 993
Rogers, Wallace A., Jr., 807 Stadium
Rosenholtz, Mitchell J., 807 Stadium Rd.
Ross, Gilbert, Jr., 807 Stadium Rd.
Royer, Jerry A., 807 Stadium
Russell, Garth, 3205 Lansing Ave.
Saunders, Carol S., TD4, 807 Stadium
Scheuber, Charles, 1504 E. Broadway
Schewe, Elmer J., Jr., 3205 Lansing Ave.
See, William B., 1504 E. Broadway
Senhauser, Donald A., 807 Stadium Rd.
Shaheen, Eleanor, 807 Stadium
Sights, Warren P., Jr., 807 Stadium Rd.
Silvers, Robert G., 610 W. Stewart Rd.
Simonds, John F., 807 Stadium
Smith, Jason N., Jr., 701 West Blvd. S.
Smith, Joe R., 1506 E. Broadway
Somers, John E., 11 S. Williams
Sosebee, Lee A., 3205 Lansing Ave.
Spratt, John S., Jr., 105 S. Glenwood Ave.
Spurgeon, Milo J., 404 Edgewood Ave.
Steffens, Richard S., Jr., 506 Joaquin, Redding, Calif. 96001
Stephenson, Hugh E., Jr., 807 Stadium Rd.
Stewart, Wellington B., Medical Computer Center, 307 Lewis Hall
Stoy, Robert P., 201 W. Broadway
Stradford, H. Todd, Rt. 1, 82 E. Chaparral
Struessel, Kenneth F., 113 W. Broadway
Sutton, Richard N., 1527 Celia, Wichita Falls, Tex. 76302
Terry, Boyd E., 807 Stadium
Thomas, Horace E., 1504 E. Broadway
Thomas, Robert M., 3205 Lansing Dr.
Thompson, Ian M., 807 Stadium Rd.

° Doctor of Osteopathy.

Thomson, James Myron, Jr., Ellis Fischel State Cancer Hospital
Tinsley, John C., Jr., 16 S. Tenth St.
Trumbower, William D., 807 Stadium
Van Dervoort, Robert L., Jr., 401 Keene
Waggoner, Charles M., 201 W. Broadway
Wakerlin, G. E., 2120 Pacific Ave., San Francisco, Calif. 94115
Walters, John H., 11 S. Williams St.
Walters, Laura, 11 S. Williams St.
Washington, Edward L., 1504 E. Broadway
Watson, Trevor F., 1504 E. Broadway
Weigel, James W., 6th St.
Weiss, James M. A., 807 Stadium Rd.
White, Joseph M., 111 Jesse Hall
Wiggins, Roland L., 408 N. Garth
Wilhelm, K. G., VA Hospital
Williams, Andrew F., 807 Stadium
Wilson, George P., 201 W. Broadway
Wilson, John E., 401 Keene St.
Windmiller, Myrl E., 1504 E. Broadway
Woodruff, Calvin W., 807 Stadium Rd.
Yeager, Helen, 807 Stadium
Young, Paul R., University of Missouri School of Medicine

BUCHANAN COUNTY MEDICAL SOCIETY
(St. Joseph)

Acuff, R. Philip, 702 Jule St. 64501
Ahad, Abdul, 3400 Frederick Ave. 64502
Ames, William H., 902 Edmond St. 64501
Andres, Edward H., 902 Edmond 64501
Bartulica, Nicholas, 422 N. 7th 64501
Beck, Paul M., Kirkpatrick Bldg. 64501
Beheler, Edward M., 422 N. 7th St. 64501
Benson, Scott C., 324 N. 6th St. 64501
Berney, Francis J., Kirkpatrick Bldg. 64501
Bristow, Robert B., 1302 Faraon 64501
Bryant, Sydney L., 902 Edmond St. 64501
Butler, Elza F., 902 Edmond St. 64501
Callman, George, State Hosp. No. 2 64502
Carpenter, George T., 902 Edmond St. 64501
Challener, William A., III, 902 Edmond 64501
Christ, Martin H., 1402 Faraon 64501
Cox, John P., 902 Edmond St. 64501
Craig, Owen W. D., Kirkpatrick Bldg. 64501
Craig, Richard O., 320 Pioneer Bldg. 64501
Day, Maxwell, 1410 Highland, McAllen, Tex. 78501
Decanini, Mario, P. O. Box 11 64502
DuMont, Clement C., 1905 Francis St. 64501
Dyer, Gary, 1302 Faraon 64501
Eller, Gordon W., 9th & Edmond 64501
Ferguson, Luther J., 2907 Francis St. 64501
Fischer, Martin J., 902 Edmond, 64501
Fisher, Joseph L., 7th & Jule Sts. 64501
Forgrave, Leon P., 1 Hundley Dr. 64506
Forman, George W., P.O. Box 830 64502
Fox, Gerald E., Methodist Hospital, 8th & Faraon 64501
Fuson, Levi H., Route 3 64506
Garrison, David L., 902 Edmond 64502
Grant, Claude S., 2726 Sublette Way 64506
Greenberg, Charles, 10669 Rochester Ave., Los Angeles, Calif. 90024
Grimes, Manning E., Kirkpatrick Bldg. 64501
Grinstein, Alberto, c/o Ypsilanti State Hospital, Ypsilanti, Mich. 48197
Gunter, Joe S., 902 Edmond St. 64501
Handler, Eric, Kirkpatrick Bldg. 64501
Harner, Casper G., 902 Edmond St. 64501
Hayes, Paul W., 902 Edmond St. 64501
Herman, Allen I., 510 Francis 64501
Howden, Thomas L., 2723 Francis 64501
Hughes, Judson M., 3306 Jennifer La. 64506
Ide, Lucien W., P. O. Box 830 64502
Jimenez, Jose, Box 263 64502
Kieber, Robert W., Kirkpatrick Bldg. 64501
Kline, Carlyn M., 17 Stonecrest St. 64506
Kline, Edmund W., 510 Francis St. 64501
Knepper, Paul A., 902 Edmond St. 64501
Kulowski, Jacob, 2404 Highly St. 64506
Lee, Carleton H., 2716 Douglas 64506
Lehman, Philip C., 510 Francis St. 64501
McDaniel, John R., 902 Edmond St. 64501
McDonald, Wallace, 305 N. 8th 64501
McDonald, Wilbur P., 301 N. 8th St. 64501
Maginn, Richard L., 702 Jule St. 64501
Marston, F. James, Jr., 902 Edmond St. 64501
Martin, John N., 1302 Faraon 64501
Meriwether, Don R., 902 Edmond 64502
Minton, Robert S., Rt. 2, 64505
Moen, Berwyn H., 902 Edmond St. 64501
Monta, Mande D., 8th & Faraon 64501
Morse, John P., 902 Edmond St. 64501
Morse, Marvin, 2702 Faraon St. 64501
Mothershead, John L., 2603 Frederick Ave. 64501
Muench, Albert H., 412 N. 25th 64501
Mullican, Charles N., 510 Francis 64501
Mullinax, Orr, Missouri Methodist Hospital, Rm. 23, 64501
Ness, Carl K., 902 Edmond St. 64501
O'Brien, Liam, State Hospital No. 2 64502
O'Connor, William B., 510 Francis St. 64501
Paculdo, Nora R., 3400 Frederick 64502
Partamian, Krikor O., 9th & Edmond 64501
Paulson, Gordon S., 510 Francis 64501
Petersen, Harold E., 2401 Frederick Ave. 64501
Pfeffer, Robert I., 1915 N. 29th St. 64506
Pifer, Lawrence H., 925 5th Ave. 64505
Potter, Caryl A., Jr., Pioneer Bldg. 64501
Prokop, Joseph R., #29 Stonecrest 64501
Raphel, Jose, 37 Northridge Dr. 64506
Redmond, William, Corby Bldg. 64501
Roberts, Phyllis Grant, 3314 Linda La. 64506
Rogers, John T., 2502 Asbland Ave. 64506
Rosenthal, Irwin I., State Hospital No. 2 64502
Rost, William B., 2221 N.W. Extension Blvd. 64506
Ryan, John H., 2901 Lovers La. 64506
Sanchez, Salvador Valera, 3400 Frederick 64506
Senne, Herbert C., 223 N. 7th St. 64501
Sheppard, Julius K., 902 Edmond 64501
Shevlin, Charles F., 902 Edmond St. 64501
Silliman, Y. E., 2631 Felix 64501
Sklenar, Donald E., 228 Illinois Ave. 64504
Stacy, Winton T., 1215 N. 24th St., 64506
Stallard, Donald J., 902 Edmond St. 64501
Stevens, Edward M., 702 Jule St. 64501
Stuber, Robert R., 1325 Village Dr. 64501
Thompson, F. Gregg, III, 2714 Ashland Ave. 64506
Tobin, Robert F., 1817 N. Belt 64501
Wadlow, Ernest E., 510 Francis St. 64501
Waggoner, Sharon E., 301 Illinois Ave. 64504
Walker, Larry G., 702 Jule
Wallace, Hilen K., 8th & Faraon 64501
Wang, Hubert K. W., 3400 Frederick 64502
Weed, Randal W., 702 Jule St. 64501
Weinand, Ernest E., 902 Edmond St. 64501
Whitsell, Ora E., 802 N. 23rd St. 64506
Willman, Charles R., 2216 Highly St. 64502
Willumsen, Henry C., 902 Edmond St. 64501
Windsor, David G., Rt. 1, Savannah 64485
Young, Thomas J., 1817 N. Belt 64501

BUTLER-WAYNE-RIPLEY-CARTER COUNTY MEDICAL SOCIETY
(Poplar Bluff 63901)

Baja, Arun R., 217 Oak
Barbour, Marvin R., Kneibert Clinic
Beecher, Sheldon B., 1517 Rosedale Ave.
Biggs, Fred J., Jr., 808 N. Main
Brookreson, Alton D., 1500 Lurlyn
Brookreson, Alton F., 217 Oak St.
Caldwell, Fred, Kneibert Clinic
Camp, Richard V., Jr., Rt. 7, Box 288
Canlas, Emilio M., P. O. Box 1009
Carlson, E. C., 623 Pine
Christy, John P., 623 Pine Blvd.
Dinelli, Frank E., 215 Oak St.
Engelhardt. Robert C., Kneibert Clinic
Fraser, Richard A., 621 Pine
Gernstetter, Sangwill L., P. O. Box 337
Hansbrough, Eugene T., 623 Pine Blvd.
Harwell, J. Lester, Plantation House, Apt. 104, 2400-44th St., Lubbock, Tex. 79412
Hecker, Joseph E., Kneibert Clinic
Hoja, W. Alexander, Kneibert Clinic
Hunt, John L., Box 56, 3600 Wilcox
Kelley, Kenneth H., 623 Pine Blvd.
Kneibert, Fred L., Kneibert Clinic
Laatsch, Robert H., 1333 Meadow Ln.
Ladyman, George H., 623 Pine St.
Leroux, Gene, Doniphan 63935
Lestmann, Henry E., 202 Plum, Doniphan 63935
Loughead, John R., 1201 Lurlyn Dr.
McLane, Jerry F., 330 N. 2nd St.
McPheeters, James W., Sr., 330 N. 2nd St.
Macauley, Bernard J., 215 Oak St.
Markel, Arthur D., Kneibert Clinic
May, Albert L., Jr., 330 N. 2nd St.
Miller, David V., Kneibert Clinic
Parker, Arthur C., Jr., Kneibert Clinic
Plunkett, Littleton J., Jr., 330 N. 2nd
Ramirez, Ricardo M., Kneibert Clinic
Raper, Charles A., 330 N. 2nd St.
Reddy, A. N., 623 Pine Blvd.
Reddy, Sarvotham K., 623 Pine Blvd.
Robertson, William D., Poplar Bluff
Ruff, T. Eugene, Kneibert Clinic
Shriver, Ronald G., 623 Pine Blvd.
Stubblefield, C. F., VA Hosp.
Tiffany, Delbert E., Rt. 7, Box 42
Till, Bennie N., 2030 Meadows
Tinsley, Austin R., 2nd and Oak
Traxel, William Louis, 623 Pine Blvd.
Tuma, Arthur T., 215 Oak St.
Turner, James H., 217 Oak St.
Turner, Kirby L., 623 Pine
Turner, William F., 217 Oak St.
Varma, D. K., 2506 N. Main
White, Barry B., 330 N. 2nd St.
Wood, Tom, Kneibert Clinic

CALDWELL COUNTY
(Grand River Medical Society)

CALLAWAY COUNTY MEDICAL SOCIETY
(Fulton 65251)

Arana, Victor A., P. O. Box 464, Falls City, Neb. 68355
Brown, John J., 101 E. 6th St.
Brown, Katherine S., 1304 Vine St.
Cremer, William J., State Hosp. No. 1
Domke, Herbert R., 221 W. High, Jefferson City 65101
Durst, Henry, 610 Court St.
Espinosa, Tomas, Fulton State Hospital
Gish, Rutledge, 5 E. 5th St.
Groce, George, 820 Jefferson St.
Hill, James E., 820 Jefferson St.
Jackson, Vernon B., State Hosp. No. 1
Osbourn, Richard A., 820B Jefferson
Peterson, Donald B., State Hosp. No. 1
Ritterbusch, James K., State Hosp. No. 1
Sydow, Henry A., 10 W. 6th
Williams, Paul A., 820 Jefferson
Wood, George F., 1700 Plaza Dr.

CAMDEN COUNTY

Carnell, B. M., Camdenton 65020 (Member Mid-Missouri County Medical Society)
Garrison, T. W., Camdenton 65020 (Member Mid-Missouri County Medical Society)
Holley, Donald B., Camdenton 65020 (Member Mid-Missouri County Medical Society)
Wayland, Thomas A., Camdenton 65020 (Member Cole County Medical Society)

CAPE GIRARDEAU COUNTY MEDICAL SOCIETY
(Cape Girardeau 63701)

Alyea, J. O., 937 Broadway
Ashley, Hugh V., 234 N. Sprigg
Bahn, Charles F., 801 S. Mount Auburn Rd.
Barnes, Seth S., 1854 Broadway
Blankenship, Dale M., Doctors' Park
Bowman, William K., 14 Doctors' Park
Burford, Edwin K., Jr., 35 Doctors' Park
Campbell, Edward D., 937 Broadway
Chapman, Jean A., 801 S. Mount Auburn Rd.
Cochran, Jo R., Doctors' Park
Coulson, Forest H., 19 Doctors' Park
Cozean, Charles H., Jr., 937 Broadway
Crowe, John T., 937 Broadway
Dinkins, James A., 36 Doctors' Park
Downey, Jon Patrick, 210 Christine
Edwards, Donald E., 937 Broadway
Elrod, Dennis B., 211 N. Sprigg St.
Essmyer, Joseph K., 937 Broadway
Herbert, Charles T., 824 Good Hope St.
Holcomb, John K., 35 Doctors' Park
Horn, Paul C., 400 Broadway
Hunt, Robert S., 10 Doctors' Park
Jaeger, Joseph N., 208 S. High St., Jackson 63755
Johnson, Earl W., 937 Broadway
Johnson, Ernest D., 937 Broadway
Jones, David N., 210 Christine
Jung, J. Marshall, Box 417, Illmo 63754
Kasten, Melvin C., 1209 Sailer Circle
Keim, John H., 1845 Woodlawn
Kinder, James A., 937 Broadway
Kinder, Jerry L., Doctors' Park
Koldys, Kenneth, Doctors' Park
Kratz, Paul E., 2560 Gordonville Rd.
Lovinggood, Thomas A., 2505 Allendale
McDonald, Eugene F ., 225 W. Main, Jackson 63755
McGinty, Charles P., 10 Doctors' Park
Magaletta, George E., 937 Broadway
Nunnelly, Gordon M., 1924 Broadway
Oehler, William F., 213 N. Sprigg St.
Otto, Thomas G., 1912 Broadway

• Doctor of Osteopathy.

Parsons, D. LeRoy, 35 Doctors' Park
Rapp, Harold B., 1011 N. Henderson St.
Rawlins, Fred E., 1607 Berthing Ave.
Ridings, Harold D., 937 Broadway
Ritter, C. John, 801 S. Mount Auburn Rd.
Ritter, Carl F., 937 Broadway
Ritter, Raymond A., 2408 Terry Hill
Ritter, Raymond A., Jr., 1912 Broadway
Roberts, Perry, Doctors' Park
Seabaugh, L. R., Doctors' Park
Seabaugh, William O. L., 24 N. Sprigg St.
Shoss, Milton, 937 Broadway
Sparkman, Thomas C., 15 Doctors' Park
Spence, Paul A., 35 Doctors' Park
Stewart, Wendell K., 723 North Sunset
Talbert, Clifford R., 801 S. Mount Auburn Rd.
Terry, James W., Jr., #18 Doctors' Park
Tygett, Glenn J., 834 Alta Vista Dr.
Tygett, Joseph N., 17 Doctors' Park
Weeks, George R., 937 Broadway
Wilson, Charles F., 714 Broadway
Wolff, Paul G., 1819 Broadway

CARROLL COUNTY
(Grand River Medical Society)

CARTER COUNTY
(Butler-Wayne-Ripley-Carter County Medical Society)

CASS COUNTY
(West Central Missouri Medical Society)

CEDAR COUNTY
(West Central Missouri Medical Society)

CHARITON-MACON-MONROE-RANDOLPH COUNTY MEDICAL SOCIETY

Arnold, Eugene L., 1429 Central Ave., St. Louis 63139
Baker, Josephine D., Moberly 65270
Barnett, Floyd A., Paris 65275
Bautista, Rogelio, 324 Circle Dr., Moberly 65270
Campbell, James E., Macon 63552
Chute, W. Deward, Moberly 65270
Cohrs, Clarence C., Moberly 65270
Collins, Gretchen D., Macon 63522
Dreyer, Philip V., Huntsville 65259
Eggleston, Donald E., Macon 63552
Fleming, J. Will, Jr., Moberly 65270
Fleming, Thomas S., Moberly 65270
Harms, Florian L., Salisbury 65281
Huber, Lasley E., Moberly 65270
Hudson, G. R., Moberly 65270
Miller, D. Herbert, 8555 S. Lewis, Apt. 201, Tulsa, Okla. 74136
Streetor, Roderick D., 245 Union Blvd., St. Louis 63108
Stuart, Daniel D., Brunswick 65236
Tompson, Robert V., 423 E. Logan, Moberly 65270

CHRISTIAN COUNTY
(Ozarks Medical Society)

CLARK COUNTY
(Lewis-Clark-Scotland County Medical Society)

CLAY COUNTY MEDICAL SOCIETY

Adams, Howard D., Suite 6, Westown Pl., Liberty 64068
Allain, James J., 2700 Hospital Ave., N. Kansas City 64116
Allan, James R., #6 Westown Pl., Liberty 64068
Allen, Louis A., 2700 Hospital Dr., N. Kansas City 64116
Andrews, Berneil W., 2700 Hospital Dr., N. Kansas City 64116
Armstrong, Jay H., 4812 Black Swan Dr., Shawnee Mission, Kan. 66216
Arst, Herbert E., 408 N.E. 68th St., N. Kansas City 64118
Balhuizen, John, 5601 N. Antioch Rd., Kansas City 64119
Bates, George C., 2700 Hospital Dr., N. Kansas City 64116
Beeks, John W., P.O. Box 11009, Kansas City 64119
Benson, Larry E., 2700 Hospital Dr., N. Kansas City 64116
Bliss, Joy V., 510 S. Kimball, Excelsior Springs 64024
Boone, Daniel C., 5800 N. Grand Ave., Kansas City 64118
Bowles, Richard P., 114 N. Water St., Liberty 64068
Brahmacupta, Nanthana, 107 S. Spring St., Excelsior Springs 64024
Brizio-Molteni, Loredana, 1441 Hillside, N. Kansas City 64116
Burke, Emmet K., 5140 Antioch Rd., Kansas City 64119
Castillo, Michael E., 2601 Kendallwood Pkwy., Kansas City 64119
Chatkupt, Suthon, 116 South St., Excelsior Springs 64024
Chiles, David R., Box 238, Smithville 64089
Cook, Jerry W., 7010 N. Cherry, Kansas City 64118
Cooper, Barry R., 2800 Hospital Dr., N. Kansas City 64116
Curnow, Richard B., Westowne Offices, Liberty 64068
Deligeorges, John, 7010 N. Cherry, Kansas City 64118
Denton, Robert E., Smithville 64089
Dernoncourt, John E., Smithville 64089
Devine, Mark W., Jr., 2700 Hospital Dr., N. Kansas City 64116
Dolan, C. Terrence, 2700 Hospital Dr., N. Kansas City 64116
Dunham, Robert H., 6022 N. Antioch Rd., Kansas City 64119
DyRagos, Ramon R., 5601 N.E. Antioch Rd., Kansas City 64119
Edwards, Theodore F., 2029 Burlington St., Kansas City 64116
Fakhoury, Donald A., 4030 N. Oak St., Kansas City 64111
Falter, Richard T., 2nd & Main, Hutchinson, Kan. 67501
Fischer, Edward H., Suite 415, 2929 Baltimore Ave., Kansas City 64108
Flanders, Virgil E., 2022 W. 91st St., Leawood, Kan. 66206
Fotopoulos, Chris K., 201 E. 21st Ave., N. Kansas City 64116
Fowler, I. Charles, 2025 Swift, N. Kansas City 64116
Galbol, Harley, 522 Elms Blvd., Excelsior Springs 64024
Gauer, Robert J., 5601 N.E. Antioch, Kansas City 64119
Gilani, Abdollah, 2700 Hospital Dr., N. Kansas City 64116
Haley, Ted M., 405 E. 19th Ave., N. Kansas City 64116
Hayes, Lawrence L., 8400 N. Oak Trafficway, Kansas City 64155
Hedges, Richard C., 402 St. Louis Blvd., Excelsior Springs 64024
Hendren, Thomas H., 201 E. 21 Ave., N. Kansas City 64116
Hodge, Robert H., 2029 Burlington Ave., Kansas City 64116
Houck, Russell M., V. A. Hospital, Kecoughtan, Va. 23367
Ise, Frank H., 2030 Swift Ave., N. Kansas City 64116
King, Phillip E., 529 N. Fairview, Liberty 64068
Kirkland, Jerry A., 8630 N. Oak Trafficway, Kansas City 64155
Kuenzi, Donald E., 8630 N. Oak Trafficway, Kansas City 64155
Lanning, R. James, 2700 Hospital Dr., N. Kansas City 64116
Latimer, Walter N. A., 5140 N.E. Antioch Rd., Kansas City 64119
Lila, Aram, 116 S. St., Excelsior Springs 64024
Littlejohn, Robert T., 2700 Hospital Dr., N. Kansas City 64116
Luechtefeld, Frank R., 2700 Hospital Dr., N. Kansas City 64116
McCluggage, Newton C., 2700 Hospital Dr., N. Kansas City 64116
McCormick, James E., 4030 N. Oak St., Kansas City 64111
McPhee, William R., 1205 W. 76th, Kansas City 64114
Mullins, Bernard L., 405 E. 19th St., N. Kansas City 64108
Muro, F. Del, 5601 N. Antioch Rd., Kansas City 64119
Musgrave, David E., Excelsior Springs 64024
Myers, David William, Jr., Commercial Ave. and Marisa St., Smithville 64089
Nourbakhsh, Mahmoud M., Platte Medical Clinic, Platte City 64079
Patterson, Carroll D., 2900 Hospital Dr. 64116
Perico, Carlos J., 405 E. 19th Ave., Kansas City 64116
Pileggi, Felix A., 405 E. 19th St., N. Kansas City 64116
Purcell, P. L., Smithville 64089
Pyron, Katharine A., 4500 15th, Gulfport, Miss. 39501
Reeder, Charles C., 620 Commercial Ave., Smithville 64089
Revare, Paul, 3245 Chippewa Dr., Kansas City 64116
Riordan, Robert H., P.O. Box 20007, Kansas City 64195
Robinson, Van M., 2700 Hospital Dr., N. Kansas City 64116
Rodas, Rizalina, 2700 Hospital Dr., N. Kansas City 64116
Sanders, George E., 617 A Willow Dr., Lee's Summit 64063
Sawyer, Floyd E., 5350 N. Oak St. Trafficway, Kansas City 64118
Schertz, Truman B., 2700 Hospital Dr., N. Kansas City 64116
Schutz, John P., 1236 Jesse James Rd., Excelsior Springs 64024
Slaughter, Carl R., 1001 N. Woodland, Kansas City 64118
° Smith, Charles H., 2025 Swift, N. Kansas City 64116
Somoza, Jose R., 2800 Hospital Dr., North Kansas City 64116
Soper, William D., 11 Westowne Center, Liberty 64068
Sportsman, Weldon L., 7504 N. Oak Street Tfwy. 64118
Stratman, Clarence A., 6002-A North Antioch Rd., Kansas City 64119
Tharp, Judith L., P. O. Box 717, Platte City 64079
Thomas, Fred A., 5601 N. Antioch Rd., Kansas City 64119
Thomas, Thomas C., P.O. Box 217, Liberty 64068
Trimble, Davd P., Jr., 510 S. Kimball, Excelsior Springs 64024
Triplett, Daniel A., 2700 Hospital Dr., N. Kansas City 64116
Tumanut, Benesto F., 2700 Hospital Dr., N. Kansas City 64116
Underwood, Johnson, III, 5140 N.E. Antioch Rd., Kansas City 64119
Vilmer, Charles, 2030 Swift, N. Kansas City 64116
Wald, Donald M., 2800 Hospital Dr., N. Kansas City 64116
Waltz, Charles A., 201 E. 21st, N. Kansas City 64116
Waltz, James R., 201 E. 21st, N. Kansas City 64116
Waterman, Franklin M., Liberty 64068
Weide, Allan R., 2700 Hospital Dr. 64116
Werner, Dean F., 2025 Swift St., N. Kansas City 64116
Werner, Franklin C., 5140 Antioch Rd., Kansas City 64119
Williams, John M., 102 S. Forest Ave., Liberty 64068
Williams, Robert D., 6700 Troost, Kansas City 64131
Williamson, G. L., 2030 Swift, N. Kansas City 64116
Wilson, David E., 8630 N. Oak Tfwy. Kansas City 64155
Withrow, John B., 2800 Hospital Dr., N. Kansas City 64116
Workman, Charles E., 2700 Hospital Dr., N. Kansas City 64116
Wright, Earl J., 2700 Hospital Dr., N. Kansas City 64116

CLINTON COUNTY MEDICAL SOCIETY

Luckenbill, Paul T., Plattsburg 64477
Ozenberger, Larry A., Plattsburg 64477
Spalding, Wilber B., Plattsburg 64477
Sweiger, James H., Plattsburg 64477

COLE COUNTY MEDICAL SOCIETY
(Jefferson City 65101)

Allan, James E., 2009 E. McCarty
Belden, Edgar A., 2124 Lowell
Bowe, Edwin Earl, 915 Leslie Blvd.
Bradley, William B., 1705 Greenberry
Bregant, Robert E., 1505 Southwest Blvd.
Busby, William E., 917-A Leslie
Clark, Kendall A., 226 E. Dunklin
Cooper, Charles W., 423 Cherry St.
Courter, Larry P., 1505 Southwest Blvd.
Cox, William A., 812 Swifts Highway
Davisson, Walter F., Jr., 913 Leslie Blvd.
Doerhoff, Adelia, Shepherd Hills Dr.
Doerhoff, Alan, Shepherd Hills Dr.
Exon, C. Stuart, 1505 Southwest Blvd.
Files, James B., Charles E. Still Hospital
Fullgrabe, E. A., 1914 Green Meadow Dr.
Garner, Lynn M., 403 Meier Dr.
Garner, Royal S., 1804 Southwest Blvd.
Gentry, Merritt L., 929 W. Crestview, Springfield 65804
° Giffen, L. E., 420 E. High

° Doctor of Osteopathy.

Gordon, James S., 915 Leslie Blvd., Suite E.
Guhleman, Henry V., Jr., 506 E. High
Gurnee, Landon H., 1431 Southwest Blvd.
Handler, Fred P., 614 Boonville Rd.
Hauser, Robert J., 1431 Southwest Boulevard
Kanagawa, Harold K., 701 W. High
Kelly, Marshall W., 612 E. High St.
Klebba, Larry B., P. O. Box 403
Leslie, James T., Jr., 1433 Southwest Blvd.
Loyd, Earl L., Riviera Heights, Holts Summit 65043
McCaffree, Mary K., 1505 Southwest Blvd.
McHaney, John W., 606 E. High St.
Matthews, John I., 701 W. High
Maxey, Hugh W., 3204 Breckenridge, Springfield, Ill 62706
Meier, Francis X., 1913 Hayselton Dr.
Meinershagen, Charles W., 111 Forest Hill
*Nemer, Robert J., Vienna 65582
Ossman, Julian A., 2407 W. Main
Robb, Harold Phillip, 722 Jefferson
Rodrigo, Bernardo R., 915 Leslie Blvd.
Russell, Joseph P., Division of Health
Ryan, Thomas J., 1433 Southwest Blvd.
Sanders, Jack S., 1505 Southwest Blvd.
Schmidt, J. H., 824 Southwest Blvd.
Schokker, Johannes, 2009 E. McCarty
Scott, E. David, 2009 E. McCarty
Sennott, John S., 1431 Southwest Blvd.
Shull, G. Donald, 1431 Southwest Blvd.
Sicat, A. V., Rt. 5, Green Acres, Warrensburg 64093
Siu, Kenneth K. C., 915 Leslie Blvd.
Stauffer, Harry B., 830 Boonville Rd.
Stricker, Harold C., 1431 Southwest Boulevard
Sugarbaker, Everett D., 503 E. High St.
Summers, Joseph S., Jr., 214 A Marshall
Tanner, Robert H., 1505 Southwest Blvd.
Taylor, Leon A., 1104 W. Main
Tietjen, Frederick O., 1433 Southwest Blvd.
Van Vranken, Eugene E., 907 Missouri Blvd.
Wallace, John K., II, 220 Ridgeway Dr.
Watts, Byron E., 1505 Southwest Blvd.
Wayland, Thomas A., Box 239, Camdenton 65020
Werth, Joseph, 917 Leslie Blvd.
Westhoff, D. Douglas, 1505 Southwest Blvd.
Winegar, Alvon C., 1431 Southwest Boulevard

COOPER COUNTY MEDICAL SOCIETY
(Boonville 65233)

Abele, Wm. A., 329 Main
Avery, Willard B., 329 Main St.
Diekroeger, Manuel L., Route 1
Hata, Daikichi, 329 Main St.
Humphreys, Edward T., 329 Main St.
Stuart, Byron M., 329 Main St.
Winn, George W., 329 Main St.

CRAWFORD COUNTY
(Mid-Missouri County Medical Society)

DADE COUNTY
(Dallas-Hickory-Polk-Dade Medical Society)

DALLAS-HICKORY-POLK-DADE COUNTY MEDICAL SOCIETY

Barnett, Charles H., Bolivar 65613
Bauer, Harold A., 3823 S. Campbell, Springfield 65804
Griffin, Evelyn, Buffalo 65622
Griffin, Olin A., Jr., Buffalo 65622
Harrell, Henry J., Rt. 1, Box 535, Summerfield, Fla. 32691
Kahler, Monte R., Bolivar 65613
Koon, Ben H., 6601 Rockhill Rd., Kansas City 64131
McCraw, Doyle C., Bolivar 65613
McNeel, Lee A., Jr., Greenfield 65661
Robinson, George G., Humansville 65674

DAVIESS COUNTY
(Grand River Medical Society)

DEKALB COUNTY
(Grand River Medical Society)

DENT COUNTY
(Mid-Missouri County Medical Society)

DOUGLAS COUNTY
(South Central Counties Medical Society)

DUNKLIN COUNTY MEDICAL SOCIETY

Benson, Leo J., Jr., Kennett 63857
Cash, Charles R., Kennett 63857
Croom, Dorwyn W., Malden 63863
Dunmire, George Q., Kennett 63857
English, Wallace D., Cardwell 63829
Garrison, Norman A., Jr., P.O. Box 588, Corinth, Miss 38834
Hopkins, Florian G., Gideon 63848
Huang, Jun-Shen, P.O. Box 526, 607 Teaco Rd., Kennett 63857
Legan, John K., Kennett 63857
Miltenberger, Paul C., Kennett 63857
Morehead, William E., Malden 63863
Palenske, Robert L., Hornersville 63855
Pu, Pin H., P.O. Box 827, Kennett 63857
Santos, Romeo I., Kennett 63857
Sisler, Maynard Lee, 217 College, Kennett 63857
Tarver, Quinton, Kennett 63857
Wilson, Loys C., Kennett 63857
Zimmerman, Joe A., Kennett 63857

FRANKLIN-GASCONADE-WARREN COUNTY MEDICAL SOCIETY

Aulenbacher, Carl E., #1 Emerson Drive, Washington 63090
Baker, Donald L., Union 63084
Bonney, Samuel C., Washington 63090
Bozzo, Raymond J., Washington 63090
Brenner, Paul A., Owensville 65066
*Calvin, Glen, Union 63084
Crane, John B., Washington 63090
Crawford, Robert M., Sullivan 63080
de la Torre, John J., Sullivan 63080
Eisenmann, Benjamin P., New Haven 63068
Eyermann, H. Walter, Warrenton 63383
Farrell, S. L., Washington 63090
Grim, George, 11811 N. 33 Circle, Phoenix, Ariz. 85029
Hoelscher, Harold F., Warrenton 63383
Mays, Frank G., Washington 63090
Mitchell, Thomas J., St. Clair 63077
Moellenhoff, Robert W., Washington 63090
Murney, Joseph A., Washington 63090
Post, John P., Washington 63090
Richardson, George A., Union 63084
Richardson, William R., Union 63084
Royse, Roy P., Sullivan 63080
Ryan, John B., Washington 63090
Schmidt, Charles A., Gerald 63037
Shea, James G., Washington 63090
Sincox, Charles H., 205 Elm, Washington 63090
Steinbeck, Herbert D., IBM Corp., Neighborhood Rd., Kingston, N. Y. 12401
Strehlman, Benjamin G., Union 63084
Workman, George M., Hermann 65041

GASCONADE COUNTY
(Franklin-Gasconade-Warren County Medical Society)

GENTRY COUNTY
(Northwest Missouri Medical Society)

GRAND RIVER MEDICAL SOCIETY
(Caldwell-Carroll-Livingston-Grundy-Daviess-Harrison-Linn-Mercer-DeKalb Counties)

Allen, E. Warren, Carrollton 64633
Atcheson, Windsor B., Trenton 64683
Bales, Eugene L., Carrollton 64633
Bohnsack, Ralph W., Brookfield 64628
Brennan, Raymond J., Chillicothe 64601
Broyles, Watkins A., Bethany 64424
Cofer, T. N., P.O. Box 905, Chillicothe 64601
Conrad, Joseph, P.O. Box 905, Chillicothe 64601
Cross, Albert D., Trenton 64683
Daley, Frank R., Hamilton 64644
Dixon, John R., Brookfield 64628
Dowell, J. Larry, Pattonsburg 64670
Duffy, Oliver F., Trenton 64683
Ellsworth, Willard, Cainsville 64632
Fair, William L., Chillicothe 64601
Fuson, William A., Trenton 64683
Gale, Joseph F., Chillicothe 64601
Galvez, Sisenande P., Jr., 105 South Kansas Marceline 64658
Gary, George, Marceline 64658
Gearhart, Merriam, Bethany 64424
George, Theodore, 1500 N. Kansas, Marceline 64658
Gilliland, Charles E., Cameron 64429
Howell, Billy D., Brookfield 64628
Kimberlin, Herbert C., Trenton 64683
McArtor, Thomas R., Browning 64630
Magill, Joseph S., Milan 63556
Mandler, George, Chillicothe 64601
Nixon, Edward E., Gallatin 64640
Platz, John H., Carrollton 64633
Rose, John F., 1024 Grandview, Chillicothe 64601
Ryan, David L., 600 E. 9th, Trenton 64683
Smith, Robert W., 616 West Locking, Brookfield 64628
Staton, R. Hamilton, Carrollton 64633
Szymanski, Stanley R., 329 N. Rollins, Macon 63552
Trinidad, Hermanito R., 913 Webster, Chillicothe 64601
Vandiver, Virgil D., Rt. 2, Chillicothe 64601
Wilson, Fred K., Winston 64689
Yoon, Jin Soo, 103 11th, Chillicothe 64601

GREENE COUNTY MEDICAL SOCIETY
(Springfield)

Allen, Jerry H., 1211 S. Glenstone St., 65804
Allen, Stephen C., 1235 E. Cherokee 65802
Allison, James B., 2200 E. Sunshine 65804
Ancheta, Apolinario A., 1715 Boonville 65803
Anthony, Dallas D., Rm. 403, Professional Bldg., 609 Cherry 65806
Ash, Charles J., Professional Bldg., 65806
Ashley, Thomas E., 1211 S. Glenstone St. 65804
Atkinson, Thomas E., Jr., 609 E. Cherry St. 65806
Auner, Cecil R., 600 S. Glenstone St. 65802
Back, Donald K., 1211 S. Glenstone St. 65804
Bailey, Alan B., 609 Cherry 65806
Baldwin, Richard, 600 S. Glenstone St. 65802
Barnhill, Floyd R., 1443 N. Robberson 65802
Bartley, Richard L., Taylor Health Center, SMSU 65802
Beisner, Donald H., 600 S. Glenstone 65802
Benson, Ronald G., 404 E. Battlefield 65807
Bentley, John D., 419 Professional Bldg. 65806
Berry, Paul T., 1740 S. Glenstone 65804
Blades, Ross D., 1211 S. Glenstone St. 65804
Bonebrake, MacDonald, Rm. 304, Professional Bldg., 609 Cherry 65806
Boone, Martin H., Jr., Rt. 2, Box 315, 65802
Borja, Egbert R., 1423 N. Jefferson 65802
Brent, Lanny R., 1443 N. Robberson 65802
Brian, William J., 229 Professional Bldg. 65806
Broaddus, Loren, 1550 E. Sunshine 65804
Brooks, John E., 609 Cherry 65806
Brown, David W., Professional Bldg. 65806
Brown, James T., 2222 E. Berkeley 65804
Burkey, Jordan W., Professional Bldg. 65806
Busiek, Erwin F., Rm. 319, Professional Bldg., 609 Cherry 65806
Busiek, Paul J., 1717 E. Grand 65804
Busiek, Urban J., Professional Bldg. 65806
Callaway, Guy D., 1155 S. Delaware St. 65804
Callaway, Guy D., Jr., 1211 S. Glenstone St. 65804
Carr, Phillip W., 1211 S. Glenstone 65804
Cheek, J. William, Rm. 419, 609 Cherry 65806
Christy, Raymond A., Jr., 1211 S. Glenstone St. 65804
Clarke, Michael J., Rm. 116, Professional Bldg., 609 Cherry 65806
Clary, William F., 2030 S. National 65804
Clawson, James W., Professional Bldg. 65806
Clayton, Edgar L., Professional Bldg. 65806
Cochran, Thomas E., Jr., 2423 Brentwood Blvd. 65804
Coller, Frederick C., 2433 Marlan St. 65802
Conrad, Raymond C., 609 Cherry St. 65806
Cook, James R., 2333 E. Glenwood 65804
Cooper, C. Wesley, 1211 S. Glenstone 65802
Cordonnier, James K., 1550 E. Sunshine 65804
Corry, Francis M., 1211 S. Glenstone 65804
Coscia, Robert, 1446 N. Robberson 65802
Coulter, James W., 1550 E. Sunshine 65804
Crawford, Oral B., Rm. 229, Professional Bldg., 609 Cherry 65806
Creighton, John C., Suite 501, 1443 N. Robberson 65802
Crostwait, Ed L., 1305 Battlefield 65804
Cunningham, Darral D., 1715 Boonville Ave. 65803
Danielsson, Ernst P., 3324 Redbud Ln. 65804
Dillard, Erin M., Professional Bldg. 65806
Dills, Joseph N., 1554 S. Campbell 65804
Dolan, Daniel L., Professional Bldg. 65806
Domann, Darrell D., 1443 N. Robberson, Suite 508 65802
Duncan, Robert D., 1550 E. Sunshine 65804
Edison, John M., 1443 N. Robberson 65802
Elkadi, Ahmed, 315 Professional Bldg. 65806
Elkins, Ronald F., 2830 E. Glenwood 65804
Ellis, Francis J., Professional Bldg. 65806
Ellis, Harry L., Professional Bldg. 65806

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Ferguson, John P., Jr., 609 Cherry 65806
Ferrell, Thomas E., Jr., 1550 E. Sunshine Blvd. 65804
Fink, Roger L., 1423 N. Jefferson 65802
Fitch, C. H. Max, 1711 Boonville Ave. 65803
Fogerson, Virginia L., 900 S. Pickwick 65804
Fogle, Philip R., 1636 S. Glenstone 65804
Francis, William C., 600 S. Glenstone St. 65802
Gaska, Walter J., 1211 S. Glenstone 65804
Gentry, Michael A., 1722 "K" S. Glenstone 65804
Gerdes, John A., St. John's Hospital 65804
German, Walter A., Jr., 1211 S. Glenstone St. 65804
Giddings, Frank C., 1443 N. Robberson 65802
Giffin, James M., Professional Bldg., 65806
Gill, Paul J., 1211 S. Glenstone 65804
Glover, Jack F., 1550 E. Sunshine 65804
Gorelick, David F., 1041 Linwood Terr. 65804
Gose, Don F., 1550 E. Sunshine 65804
Gwin, Edward, 1515 E. Sunshine 65804
Haen, Charles J., 1630 N. Jefferson 65803
Hall, David W., Rt. 2, Rogersville 65742
Hall, Durward G., 2442 S. Fremont 65804
Hamburg, Frederic L., 114 Professional Bldg. 65806
Hanan, Ernest B., 724 E. Kingsbury 65804
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Harrison, Stratton W., Professional Bldg. 65806
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H'Doubler, Francis T., Jr., 1443 N. Robberson 65802
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Hollis, Richard W., Professional Bldg. 65806
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Horton, James D., 1235 E. Delmar 65804
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Ippensen, John H., 1443 N. Robberson 65802
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Johnson, Fritz M., 609 Cherry 65806
Johnson, George A., 229 Professional Bldg. 65806
Johnson, George L., 1443 N. Robberson 65802
Johnson, Joseph C., Jr., 1211 S. Glenstone 65804
Johnson, Warford B., Rm. 330, Professional Bldg., 609 Cherry 65806
Johnson, William F., Professional Bldg. 65806
Johnston, Joseph L., 2855 Southern Hills Blvd. 65804
Jones, Harold L., 1550 E. Sunshine 65804
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Kinder, Doyle D., 1211 S. Glenstone 65804
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Klingner, George M., 1630 N. Jefferson St. 65803
Klingner, George M., Jr., 1630 N. Jefferson 65803
Klinkerfuss, George H., 609 E. Cherry 65806
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Kobbermann, Kobby J., 1636 S. Glenstone 65804
Kolze, Vernon W., 600 S. Glenstone 65802
Krahn, Henry C., 1443 N. Robberson 65802
Langston, Walter R., 1453 Fairway Terr. 65804
Le Fevre, Philip J., 2030 S. National 65804
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Lemmon, George B., Prof. Bldg. 65806
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Lorenc, Ernest, Professional Bldg. 65806
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Lowe, Horace A., Jr., 114 Professional Bldg. 65806
Lundman, Hugh, 116 Professional Bldg. 65806
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Pruett, Paul L., Professional Bldg. 65806
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Raborar, Arteso C., 207 Professional Bldg. 65806
Rainwater, Elmer H., Professional Bldg. 65806
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Rigney, Levi M., 806 E. Linwood Dr. 65804
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Sala, Jose M., 1423 N. Jefferson Ave. 65803
Sammon, T. James, 609 Cherry 65806
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Shane, Ramon A., Rm. 404, Professional Bldg., 609 Cherry 65806
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Shields, Lawrence S., Taylor Health Clinic, SMSU 65802
Siceluff, Joseph G., Rm. 224, Professional Bldg., 609 Cherry 65806
Silsby, Don J., Rm. 401, Professional Bldg., 609 Cherry 65806
Silsby, Harry D., 1369 S. Fairway Ave. 65804
Simpson, Albert P., 1636 S. Glenstone 65804
Simpson, Emerson L., 1630 N. Jefferson Ave. 65803
Smith, C. Souter, 1223 S. Kenwood 65804
Snead, William H., Jr., 609 Cherry 65806
Snow, Emasue, 440 S. Market 65806
Spalding, David L., Professional Bldg. 65806
Sponenberg, Don E., 1211 S. Glenstone 65804
Stamatis, John J., 609 Cherry, Suite 404 65806
Stehr, Christian H., 609 Cherry 65806
Stewart, Robert B., 600 S. Glenstone St. 65802
Stewart, R. Wendell, Rm. 219, Professional Bldg., 609 Cherry 65806
Stubblefield, Wayne, 2740 S. Glenstone 65804
Stufflebam, Robert E., 2323 E. Rosebrier 65804
Sturtevant, Harwood N., Rm. 403, Professional Bldg., 609 Cherry 65806
Sullivan, Dan T., 609 Cherry 65806
Sundstrom, Frank D., 1211 S. Glenstone St. 65804
Suva, Morfeo M., 440 S. Market 65802
Sweeney, Thomas P., Professional Bldg. 65806
Tarrasch, Ernest L., 1636 S. Glenstone St. 65804
Taylor, William E., Rt. 9, Box 313, 65803
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Terry, James F., 609 Cherry 65806
Thomasson, David D., 600 S. Glenstone St. 65802
Tillman, Walter W., Jr., Rm. 229, Professional Bldg., 609 Cherry 65806
Tombridge, Thomas L., 235 E. Cherokee 65804
Trotter, W. Yates, 1243 E. Catalpa 65804
Tsang, John L. K., 1636 S. Glenstone St. 65804
Turner, Glenn O., Professional Bldg. 65806
Vensel, Lee H., 114 Professional Bldg. 65806
Waddell, Kenneth E., 1211 S. Glenstone St. 65804
Wakeman, J. Newton, 600 S. Glenstone St. 65802
Wakeman, J. Newton, Jr., 1550 E. Sunshine 65804
Walker, William M., Professional Bldg. 65806
Wantuck, Donald K., 418 Professional Bldg. 65806
Warren, William H., 1423 N. Jefferson 65802
Warres, Herbert L., 609 Cherry 65806
Waterfield, Jim R., 1211 S. Glenstone St. 65804
Webb, Leslie R., Jr., 1243 E. Loren 65804
White, R. Ned, 404 E. Battlefield 65807
Whitlock, C. Courtney, 1443 N. Robberson #405 65802
Williams, John W., 600 S. Glenstone St. 65802
Wilson, Roy E., 1211 S. Glenstone St. 65804
Winsky, Arlen D., 1443 N. Robberson, Suite 508 65802
Wise, Gordon F., Rm. 229, Professional Bldg., 609 Cherry 65806
Wittmer, Samuel C., 600 S. Glenstone St. 65802
Wong, George, Jr., 2030 S. National 65804
Wooldridge, Wilfred E., Professional Bldg. 65806
Wyrsch, Leo M., Jr., 304 Professional Bldg. 65806
Yancey, Daniel L., 1133 S. Weller 65804
Zahn, Robert L., Professional Bldg. 65806

GRUNDY COUNTY
(Grand River Medical Society)

HARRISON COUNTY
(Grand River Medical Society)

HENRY COUNTY MEDICAL SOCIETY

Bradshaw, William D., Medical Clinic, Clinton 64735
Hollingsworth, Ray S., Clinton 64735
Hughes, Shelby B., Clinton 64735
Jones, Edna M., Clinton 64735
King, Richard H., Medical Clinic, Clinton 64735
Scott, Kenneth F., Hospital Drive, Clinton 64735
Smith, James O., Clinton 64735
Smith, William J., Windsor 65360
Wetzel, Gus S., Clinton 64735

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* Doctor of Osteopathy.

HICKORY COUNTY
(Dallas-Hickory-Polk-Dade County Medical Society)

HOLT COUNTY
(Northwest Missouri Medical Society)

HOWARD COUNTY MEDICAL SOCIETY

Dean, Francis D., Fayette 65248
Leech, Maurice P., Fayette 65248
Marshall, William G., Glasgow 65254
Shaw, William J., Jr., Fayette 65248

HOWELL COUNTY
(South Central Counties Medical Society)

IRON COUNTY
(Mineral Area County Medical Society)

JACKSON COUNTY MEDICAL SOCIETY
(Kansas City)

Aaron, George A., 1515 W. Truman Rd., Independence 64050
Abaqueta, Gamaliel P., 729 E. 70th 64131
Abdou, Nancy L., 2411 Holmes 64108
Abella, Bienvenido Z., 6400 Prospect 64132
Abend, Melvin N., 6724 Troost 64131
Abercrombie, Keith J., 6700 Troost 64131
Abrams, Bernard M., 751 E. 63rd St., 64110
Adelman, Arthur, 601 E. 63rd St. 64110
Adler, Federico, 6724 Troost 64131
Agee, Loren G., 11201 Colorado 64137
Aks, Daniel, 6724 Troost 64131
Alberg, Marvin R., 3525 N.W. 60th Terrace 64151
Alderman, Donald P., 3221 W. 83rd, Shawnee Mission, Kan. 66206
Alderman, Thomas F., 7540 Troost 64131
Allebach, H. K., 6400 Prospect 64132
Allen, Robert E., 4320 Wornall Rd. 64111
Alsop, Webb S., Jr., 6400 Prospect 64132
Altomare, Edward P., 1030 W. 65th 64113
Ames, Mary B., VA Hospital 800 Stadium, Columbia 65201
Ammatelli, Francis J., 7546 Troost St. 64131
Amoury, Raymond A., 24th & Gillham Rd. 64108
Anderson, Raymond B., 24th & Gillham Rd. 64108
Andrus, Bailey C., 4320 Wornall Rd. 64111
Arbab, Ali A., 751 E. 63rd 64110
Arms, Arnold V., 4320 Wornall Rd. 64111
Arnold, John D., 2322 Holmes 64108
Arribas, Aurora I., 215 S. Sibley, Buckner 64106
Arribas, Romeo F., 1212 Luttrell, Blue Springs 64015
Aschman, Theodore H., 8740 Brooklyn 64132
Ashby, Jennifer D., 24th & Cherry 64108
Ashcraft, Keith W., 4320 Wornall Rd., 232 Medical Plaza 64111
Asher, A. Graham. 4706 Broadway 64112
Asnani, Mithlesh G., 825 Euclid 64124
Atwell, Floyd C., 4320 Wornall Rd. 64111
Averill, Keith H., 2316 E. Meyer Blvd. 64132
Ayotte, Nancy C., 5519 Crestwood Dr. 64110
Babu, Sylvia S., 825 Euclid 64124
Baer, Alvin J., 751 E. 63rd St. 64110
Baker, Philip J., 9306 E. 40 Highway, Independence 64055
Ballard, V. Bryce, 4320 Wornall Rd. 64111
Bankuti. Ferenc, 6400 Prospect 64132
Bare, Chester I., Jr., 7013 Lake Shore Dr. 64133
Barelli, Pat A., 2929 Baltimore 64108
Barloon, James H., 6700 Troost 64131
Barnard, John L., Jr., 4320 Wornall Rd. 64111
Barnett, Gordon P., 6568 High Dr., Shawnee Mission, Kan. 66208
Barr, Glenn A., 601 E. 63rd St. 64110
Barry, Gerald W., 1948 E. Parvin Rd. 64116
Barry, William B., 4320 Wornall Rd. 64111
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Bass, Lewis N., 2310 Linwood 64109
Bass. Walter R., 8800 E. 63rd 64133
Battmer, Robert E., 4320 Wornall Rd. 64111
Bauer, Lafe W., 4814 W. 80th. Prairie Village, Kan. 66208
Baum, Frank E., 6724 Troost 64131
Bay, Merrill R., Rt. 2, Box 440, Blue Springs 64015
Bayer, William L., 4040 Main 64111
Beall, M. Scott, 6700 Troost 64131
Beard, William J., 400 N. Murray, Lee's Summit 64063
Beatty, Arch J., 917 McGee 64106
Beatty, Eugene C., 24th & Gillham Rd. 64108
Beatty, Nina D., 24th & Gillham Rd. 64108
Beck, Calvin E., 4320 Wornall Rd. 64111
Becker, Richard R., 5622 Holmes 64110
Becker, Rolfe A., 601 E. 63rd St. 64110
Beckloff, Gerald L., 10236 Bunker Ridge Rd. 64137
Behrends, Steven H., 24th & Cherry 64108
Bell, Hubert H., 4320 Wornall Rd. 64111
Bell, William F., 615 W. 3rd St., Lee's Summit 64063
Bennett, James D., 6700 Troost 64131
Benoit, Hector W., Jr., 4620 Nichols Parkway 64112
Benson, William F., 4320 Wornall Rd. 64111
Berenson, Sheldon E., 4620 Nichols Parkway 64112
Bergmann, Victor H., 105 Ward Parkway 64112
Berlin, Roger, 751 E. 63rd 64110
Bernreiter Michael, 1246 W. 63rd St. 64113
Berry, Maxwell G., 4320 Wornall Rd. 64111
Bickley, James E., 4620 Nichols Pkwy. 64112
Bidwell, Robert E. G., 4320 Wornall Rd. 64111
Biery, Richard M., Health Dept., 10th Floor, City Hall, 64106
Biggs, Alfred D., 6400 Prospect Ave. 64132
Biggs, Harry L., 63rd & Evanston 64133
Bikales, Victor W., 751 E. 63rd St. 64110
Bills, Marvin L., Plaza Time Bldg. 64112
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Black, Eugene C., 3201 W. 67th, Shawnee Mission, Kan. 66208
Black, Thomas C., Jr., 601 E. 63rd 64110
Blim, Richard D., 4320 Wornall Rd. 64111
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Borenstine, Joseph, 601 E. 63rd St. 64110
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Boyd, George K., 5111 Independence Ave. 64124
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Boylan, Peter C., 6306 Morningside Dr. 64113
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Bradford, John F., 4320 Wornall Rd. 64111
Brams, Jack B., 601 E. 63rd St. 64110
Braverman, Abe E., 8300 Troost 64131
Bravo, Cesar A., 2316 E. Meyer Blvd. 64132
Brick, Jeffrey M., 6724 Troost 64131
Brower, Clyde L., 1515 W. Truman Rd., Independence 64052
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Brown, Elwyn S., 24th & Gillham Rd. 64108
Brown, Irwin S., 4320 Wornall Rd. 64111
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Brown, Robert S., 2929 Baltimore 64108
Brown, Violeta O., 24th & Gillham Rd. 64108
Brumm, Lawrence W., 6400 Prospect 64132
Bruner, Robert E., 14909 Little Blue Rd. 64136
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Buckner, Robert C., Plaza Parkway Bldg. 64112
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Buhler, Victor B., 2510 East Linwood Blvd. 64128
Buie, Bruce R., 11201 Colorado 64137
Bunthrarungroj, Tasanaporn, 825 Euclid 64124
Bunting, Williston P., 305 W. 43rd St. 64111
Burry, Virgil F., 24th & Gillham Rd. 64108
Butcher, Robert W., 7924 Paseo 64131
Butterworth, Nelson S., 725 W. 49th Terr. 64112
Caffrey, Raymond J., 1314 W. Red Bridge 64114
Caldwell, John K., 6700 Troost 64131
Calovich, Emery R., 4620 Nichols Parkway 64112
Camacho, Homero, #240 Rockhill Medical Building 64131
Campbell, Frederick B., 315 Nichols Rd. 64112
Campbell, John G., 6724 Troost 64131
Canent, Ramon V., Jr., 24th & Gillham 64108
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Carter, James E., 6723 Troost 64131
Caruso, Alfred A., 1027 E. 75th Way 64131
Case, William F., 11201 Colorado 64137
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Cattaneo, Ernest A., 2929 Baltimore 64108
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Chaudhuri, Tapan K., 9406 E. 63rd 64133
Chernoff, Selbert G., 4601 Independence Ave. 64124
Childs, Donnalea S., 6301 Rockhill Rd. 64131
Childs, Richard M., 4320 Wornall Rd. 64111
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Churchill, Stephen W., 6301 Rockhill Rd. 64131
Clark, Irving H., 5801 E. 113th St. 64134
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Cobb, Sanford, 10236 Bunker Ridge Rd. 64137
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Cohen, Robert A., 601 E. 63rd 64110
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Cortner, Mary C., 6700 Troost 64131
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Crockett, James E., 4320 Wornall Rd. 64111
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Csaki, Bela, 6700 Troost 64131
Curran, Desmond, Federal Reserve Bank Bldg. 64106
Curts, Calvin J., 4320 Wornall Rd. 64111
Cutcliff, Daniel J., 6700 Troost 64131
Dalton, Timothy T., 6400 Prospect 64132
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• Doctor of Osteopathy.

Constitution and Bylaws

of the

Missouri State Medical Association

Adopted 1903

1975 Revision

113 MADISON JEFFERSON CITY, MO. 65101

Constitution

ARTICLE I. NAME OF THE ASSOCIATION

The name and title of this organization shall be the lissouri State Medical Association.

ARTICLE II. PURPOSE

The purpose of this Association is the promotion of ie science and art of medicine, the protection of pubc health, the betterment of the medical profession, nd, by uniting with similar organizations in other ates and territories of the United States, to form the merican Medical Association.

ARTICLE III. MEMBERSHIP

Membership in this Association shall be limited to nd include all members in good standing in compoent societies which hold charters from this Associaon.

ARTICLE IV. HOUSE OF DELEGATES

The House of Delegates shall be the legislative body f this Association and shall consist of delegates elected y the component societies as well as all Past-Presients of the Association, the Speaker and Vice-Speaker, ho will serve as Delegates-at-Large. It shall elect a peaker and Vice-Speaker from its body. Its Secretary hall be the Secretary of the Missouri State Medical Asociation.

Included also in the House of Delegates shall be two udent delegates, each from a different class, elected y the student body of each of the medical schools in he State of Missouri, who shall have the same rights nd privileges as other delegates.

ARTICLE V. COUNCIL

The Council shall be the executive body of this Asociation when the House of Delegates is not in session. t shall be the judicial body of the Association when iatters are referred to it for decision by the Associaion, by component societies or by individual members hereof. It shall consist of the President, President-lect, Immediate Past-President, Secretary, Treasurer nd the duly elected Councilors from each Councilor istrict. Nine members shall constitute a quorum.

ARTICLE VI. SESSIONS AND MEETINGS

Section 1. The Association shall hold an Annual Sesion at a place fixed by the House of Delegates, the ime of which shall be fixed by the Council.

Sec. 2. Special meetings of the Association or of the Iouse of Delegates may be called by a two-thirds vote f the Council and shall be called upon a petition igned by members equal in number to one third of the otal number of delegates certified for the last Annual ession.

ARTICLE VII. OFFICERS

Section 1. The officers of this Association shall be a resident, a President-Elect, three Vice-Presidents, a Secretary, a Treasurer, a Speaker and a Vice-Speaker of the House of Delegates and ten Councilors selected as provided for.

Sec. 2. All officers except Councilors shall be elected annually. The terms of Councilors shall be two years. Half of the membership of the Council shall be elected each year. The Secretary and the Treasurer shall be elected by the Council. The delegates present from each Councilor District shall meet prior to the last day of the Annual Session and elect the Councilor from that district. In the event of death, resignation or removal of any Councilor, the Council may appoint a successor to serve until the vacancy is filled at the next Annual Session. All of the officers shall serve until their successors are elected and installed.

ARTICLE VIII. FUNDS, EXPENSES AND BUDGET

Funds shall be raised by a per capita assessment on each component society. The amount of the assessment shall be fixed by the House of Delegates. Funds may also be raised in any other manner approved by the House of Delegates. The Council shall submit an annual budget to the House of Delegates. All resolutions providing for appropriations shall be referred to the Council and all appropriations approved by the Council shall be included in the annual budget.

ARTICLE IX. REFERENDUM

At any General Meeting of the Association it may, by a two-thirds vote, order a general referendum upon any question pending before the House of Delegates. The House of Delegates may, by a vote of its members, submit any question to the membership of the Association for its vote. A majority vote of all members of the Association shall determine the question.

Petitions signed by 10% of the active members of the Association, including petitioners representing at least one half of the component Medical Societies, will initiate a referendum regarding changes in the Constitution and Bylaws or questions before the House of Delegates. A two-thirds vote of all active members of the Association responding will determine the question.

ARTICLE X. SEAL

The Association shall have a common seal. The power to change or renew the seal shall rest with the House of Delegates.

ARTICLE XI. AMENDMENTS

The House of Delegates may amend any article of this Constitution by a two-thirds vote of the delegates present and voting at any Annual Session, provided that such amendment shall have been presented in open meeting at the previous Annual Session and that it shall have been published twice during the year in the Journal of this Association or sent officially to each component society at least two months prior to the meeting at which final action is to be taken.

Bylaws

CHAPTER I. MEMBERSHIP

Section 1. Members of this Association shall be physicians whose names have been certified by secretaries of component societies to the Secretary of this Association that they are duly elected members of a component society and are legally qualified physicians practicing in Missouri except as otherwise provided. Each member must be of good moral and professional standing, and must not support, nor practice, nor claim to practice any exclusive system of medicine.

Sec. 2. No person who is under sentence of suspension or expulsion from any component society of this Association or whose name has been dropped from its roll of members shall be entitled to any of the rights or benefits of this Association.

Sec. 3. There shall be three classes of members as follow:

Active members shall be limited to those members of component societies who (1) hold the degree of Doctor of Medicine or Bachelor of Medicine, and (2) if permitted by the bylaws of the component society, members who hold the degree of Doctor of Osteopathy, and (3) are entitled to exercise the rights of active membership in their component societies, as determined by their component societies, subject to the provisions of these Bylaws.

Junior members shall be limited to those members of component societies who are serving a full-time training internship or residency in a hospital approved by the American Medical Association and shall enjoy all of the privileges of active membership.

Honor members shall be limited to Honor members of component societies, which societies have requested that active members who have reached advanced years and have long served the Association and the profession be made Honor members of the Association. They shall enjoy all the privileges of active membership and shall be exempt from the payment of dues.

Sec. 4. **Associate members** shall be limited to persons not provided for in the various classes of membership who are engaged in the pursuit of a medical or allied science, and by action of the component societies, become Associate members of the Association. Associate members shall have the right to attend scientific sessions and such other privileges as may be extended to them by the House of Delegates. They shall not be eligible to vote and shall be exempt from the payment of dues.

CHAPTER II. GENERAL MEETINGS

Section 1. The General Meetings shall be open to a registered members and guests.

Sec. 2. Any paper read before this Association sha be considered for publication in the Journal if the Author so desires. Such papers may be given publicatio priority over regularly submitted papers but shall b subject to the same editorial review and selection policies.

Sec. 3. No person in the active practice of medicin in the State of Missouri shall appear on the prograr of the Association unless he or she is a member of th Missouri State Medical Association or an affiliated association or organization.

CHAPTER III. HOUSE OF DELEGATES

Section 1. The House of Delegates shall meet annually at the time and place of the Annual Session. I shall remain in continuous session on the first day o the Annual Session and complete the work coming before it at that session.

All resolutions to be considered by the House of Delegates must be received at the Association office 4 days prior to the opening session of the House for publication in the handbook. Any resolution to be introduced after that time must be made available to th House of Delegates 24 hours before the session i which it is to be introduced. At least 200 copies of th resolution or funding for same must be supplied by th individual or society introducing the resolution.

At the second session of the House of Delegates, th same procedure would be followed, but such introduction would be allowed only if approved by two third of the delegates voting. It (The House of Delegates shall meet on the last day of the annual session to receive the report of the Nominating Committee an complete unfinished business and the election of officers. The same procedure with regard to resolution would be followed at that session, but it would the take a unanimous vote of the House to allow such introduction. At the discretion of the Speaker, these conditions would not apply for resolutions of good wishe condolences, congratulations and others of a persona nature.

Sec. 2. Each component county society shall be entitled to send each year one delegate or one alternat to the House of Delegates for each fifty full paid members or fraction thereof in the Association on Decembe l of the previous year, plus one additional delegate alternate for each one hundred members or a major action thereof; provided, however, that each compo- nt society which is composed of two or more county cieties shall be entitled to at least one delegate from ch of the counties of which it is composed; and pro- ded that when two or more counties hereafter com- ne into a hyphenated society, such society shall not se any delegates by reason thereof; however, such legates must reside or practice in the county they present. Alternate delegates may be elected from the tire membership of the component medical societies. ll Past-Presidents of the Association, the Speaker and ice-Speaker shall serve as Delegates-at-Large.

Sec. 2A. Each of the medical schools in the State of issouri shall be entitled to send each year two student elegates, each from a different class, elected by the udent body of the said medical school. The names of ch student delegates shall be certified by the Dean said medical school to the Secretary of this Associa- on thirty days before the Annual Session. Such stu- ent delegates shall have all the rights and privileges all other delegates.

Sec. 3. Forty delegates shall constitute a quorum of e House of Delegates. All meetings of the House of elegates shall be open to members of the Association.

Sec. 4. From among members of the House of Dele- ates the Speaker shall appoint reference committees which reports and resolutions, on a majority vote of e House of Delegates, shall be referred as follows:

Reference Committee on Amendments to the Consti- tion and Bylaws.

Reference Committee on Resolutions.

Reference Committee on Miscellaneous Affairs.

Reference Committee on Medical Education and ublic Welfare.

Reference Committee on Reports of Officers.

The Speaker may appoint such other reference com- ittees as he may deem necessary, upon approval of e House of Delegates.

The President shall appoint a Committee on Creden- als.

Sec. 5. The House of Delegates shall elect delegates nd alternates to the House of Delegates of the Amer- an Medical Association in accordance with the con- titution and Bylaws of that body.

Sec. 6. The House of Delegates shall divide the state to Councilor Districts specifying what counties each istrict shall include and, when the best interest of the ssociation and the profession will be promoted there- y, organize in each a district medical society of which ll members of the component county societies shall be embers.

Sec. 7. The House of Delegates shall have authority to appoint committees for special purposes from among members of the Association who are not members of the House of Delegates. Such committees shall report to the House of Delegates and may be present and participate in the debate on their reports.

Sec. 8. The House of Delegates shall receive and act upon a complete and detailed annual audit of receipts and expenses of the preceding year and a proposed budget for the current calendar year which shall have been prepared by the Council and submitted to the component county societies at least four weeks prior to the Annual Session. These shall be published in the Journal.

Sec. 9. The following shall be the general order of business of the House of Delegates for the first meeting of the session:

1. Call to order by the Speaker.
2. Report of the Committee on Credentials.
3. Roll call.
4. Reading and adoption of minutes.
5. Report of officers.
6. Report of committees.
7. Unfinished business.
8. New business.

The following shall be the general order of business of the House of Delegates for the last meeting of the session:

1. Call to order by the Speaker.
2. Report of the Committee on Credentials.
3. Roll call.
4. Reading and adoption of minutes.
5. Report of the Nominating Committee.
6. Election of officers.
7. Reports of officers.
8. Reports of committees.
9. Unfinished business.
10. New business (see Sec. 1, Chap. III).
11. Installation of officers.
12. President's appointments and installation of members to committees.
13. Selection of the place for the next Annual Session.

At any meeting of the House of Delegates, the order of business may be changed by a two-thirds affirmative vote of the members present and voting.

CHAPTER IV. ELECTION OF OFFICERS

Section 1. The President on the first day of the Annual Session shall select a Committee on Nominations consisting of ten delegates, no two of whom shall be from the same Councilor District. The Committee on Nominations shall report the result of its deliberations to the House of Delegates in the form of a ticket containing the name of one member for each of the offices listed in Article VII of the Constitution which are to be filled at that Annual Session excepting the President-Elect who shall be nominated from the floor of the House of Delegates.

Sec. 2. All elections of officers shall be by acclamation unless ballot is called for. A majority of the votes cast shall be necessary to elect except for delegates and alternates to the American Medical Association, who shall be elected as follows:

In case no delegates or alternates for the American Medical Association receive on the first ballot a majority of the votes, the nominees shall be declared elected in the order of the highest number of votes received until the allotted number shall have been chosen. In case of a tie vote for delegate or alternate, the tie shall be determined by lot.

In case no nominee for general offices of the Association (see Article VII, Constitution) receives a majority of the votes on the first ballot, the nominee receiving the lowest number of votes shall be dropped and a new ballot taken. This procedure shall be continued until one of the nominees receives a majority of all the votes cast, when he shall be declared elected.

Sec. 3. Nothing in this chapter shall be construed to prevent additional nominations being made from the floor by members of the House of Delegates.

Sec. 4. Delegates present at the Annual Session from Councilor Districts whose Councilors' terms expire shall hold meetings on or before the morning of the last day of the Annual Session and elect a Councilor for their District for a term of two years. The name of the elected Councilor shall be given on a prescribed form to the Secretary for presentation to the House of Delegates. Each candidate for Councilor must reside or practice in the district for which he is elected.

Sec. 5. The Speaker and Vice-Speaker shall not serve more than three consecutive terms.

Sec. 6. The Speaker shall appoint a parliamentarian to serve as such during the session of the House of Delegates at each Annual Session and upon whom the Speaker may call before deciding points of order or procedure.

CHAPTER V. DUTIES OF OFFICERS

Section 1. The **President**, or his designated representative, shall preside at all scientific sessions of the Association. He shall preside at the House of Delegates in the absence of the Speaker or Vice-Speaker and until their successors are elected. He shall appoint a committees not otherwise provided for. He shall delive an annual address at such time as may be arranged an shall perform such other duties as custom or parlia mentary usage requires. He shall be the real head c the profession of the state and assist the Councilors i building up the county societies and in making thei work more practical and useful.

Sec. 2. The **President** and the **President-Elect** sha be members of the Council and shall attend all meet ings of the Council. Should the office of President Elect become vacant through death or otherwise th Council may fill the vacancy until the next Annual Ses sion of the Association.

Sec. 3. The **Vice-Presidents** shall assist the Presiden in the discharge of his duties. In the event of the death resignation or removal of the President the Counc shall select one of the Vice-Presidents to serve the un expired term.

Sec. 4. The **Treasurer** shall give bond in the sum o $20,000. He shall demand and receive all funds du the Association, together with bequests and donations He shall pay money out of the treasury only on a writ ten order of the President, countersigned by the Secre tary; he shall subject his accounts to such examinatio as the House of Delegates may order, and he shall an nually render an account of his actions and of the stat of the funds in his hands.

Sec. 5. The **Secretary** shall attend the General Meet ings of the Association and the meetings of the Hous of Delegates, and shall keep minutes of their respectiv proceedings in separate record books. He shall be Sec retary of the Council and shall keep a record of its pro ceedings. He shall be custodian of all record books an papers belonging to the Association, except such a properly belong to the Treasurer, and shall keep ac count of and promptly turn over to the Treasurer a funds of the Association which come into his hands. H shall provide for the registration of the members an delegates at the Annual Session. He shall, with the co operation of the secretaries of the component societies keep a card index register of all the legal practitioner of the state by counties, noting on each his status in re lation to his county society, and shall transmit a cop of this list to the American Medical Association, trans mitting to its Secretary each month a report containin the names of new members and the names of thos dropped from the membership roster during the pre ceding month. He shall conduct the official correspon dence, notifying members of meetings, officers of thei election and committees of their appointment an duties. He shall employ such assistants as may be or dered by the Council and shall make an annual repor the House of Delegates. He shall supply all compoent societies with the necessary blanks for making eir reports and shall collect from them the regular er capita dues and assessments and turn the same over the Treasurer. The amount of his salary shall be xed by the Council.

CHAPTER VI. COUNCIL

Section 1. The Council shall meet during the Annual ession at such times as necessity may require, subject the call of the Chairman or on petition of three ouncilors. It shall meet on the last day of the Annual ession to organize. The Council shall elect a Chairman nd a Vice-Chairman for a term of one year. The hairman may be reelected to serve not more than four onsecutive terms of one year each. The Council shall, hrough its Chairman, make an annual report to the ouse of Delegates.

Sec. 2. Each Councilor shall be organizer, peaceaker and censor for his district. He shall visit each ounty in his district at least once a year for the purose of organizing component societies where none xists, for inquiring into the condition of the profesion, and to keep in touch with the activities of and to id in the betterment of the component societies of his istrict. He shall make reports of his work and the conition of the profession of each county in his district to he Council. The necessary traveling expenses incurred y each Councilor in the line of duties herein imposed ay be allowed on a proper itemized statement subitted monthly and within the current year, but this hall not include his expense in attending the Annual ession of the Association. No Councilor shall be eligile for the position of Delegate to the House of Deleates during his term of office as Councilor, nor shall e vote in the House of Delegates.

Sec. 3. The Council shall be the executive body of he House of Delegates and between sessions shall exrcise the power conferred on the House of Delegates y the Constitution and Bylaws.

Sec. 4. The District Councilor together with two embers of component societies within the Council istrict, selected by the Councilor, shall serve as a oard to hear and by a majority vote adjudicate any uestions involving the right and standing of members, ither in relation to other members or to component soieties or to the Association, and all matters of discline affecting the conduct of members of component ocieties, or other matters.

The Council shall be the appellate Board of Censors f the Association. It shall hear and adjudicate all maters on appeal from the decision of the Councilor oard; it shall hear and adjudicate matters of an ethical nature brought before the House of Delegates or the general meeting which shall be referred to the Council without discussion. On original decision or appellate determination, its decision shall be final unless appealed to the then convened meeting or the next meeting of the House of Delegates.

Sec. 5. Charters shall be issued to county societies only on approval of the Council, and shall be signed by the President and Secretary of this Association. Upon the recommendation of the Council, the House of Delegates may revoke the charter of any component society whose actions are in conflict with the letter or spirit of this Constitution and Bylaws.

Sec. 6. In sparsely settled sections the Council shall have authority to organize the physicians of two or more counties into societies, to be suitably designed so as to distinguish them from district societies, and these societies, when organized and chartered, shall be entitled to all rights and privileges provided for component societies until such counties shall be organized separately.

Sec. 7. The Council shall provide for and supervise the issuance of all publications of the Association including proceedings, transactions and memoirs, and shall have authority to appoint an Editor and such assistants as it deems necessary. It shall prescribe the methods of accounting and through a committee of three of its members, to be known as a Committee on Auditing and Appropriations, shall audit all accounts of this Association. The Council shall adopt an annual budget providing for the necessary expenses of the Association for the following calendar year. This budget shall be prepared and presented for consideration in the last quarter of each year by the Committee on Auditing and Appropriations. A complete and detailed report shall be submitted to the component county medical societies as provided in Section 8, Chapter III. The Council shall submit an annual report of the House of Delegates which shall specify the character and cost of the publications of the Association, the amount and character of all its property, and shall provide full information concerning the management of all affairs of the Association which the Council is charged to administer.

Sec. 8. The Council shall appoint at least six months before the Annual Session, a committee consisting of three of its members to be known as the Committee on Arrangements for the Annual Session. On recommendation of the Committee, the Council shall appoint a general chairman of a Local Committee on Arrangements, who shall be a member of the component society of the county in which the Annual Session is to be held, and who shall appoint and organize from the members of this county society the personnel of the Local Committee on Arrangements. The Local Committee on Arrangements shall provide suitable meeting places and shall have general charge of all local arrangements subject to the approval of the Committee on Arrangements for the Annual Session. All receipts and disbursements related to the Annual Session shall be handled by the Committee on Arrangements on recommendations of the Committee on Budget and Appropriations.

Sec. 9. The Council shall by appointment fill any vacancy in office not otherwise provided for which may occur during the interval between Annual Sessions of the House of Delegates; the appointee shall serve until his successor has been elected and has qualified.

Sec. 10. The salaries of all employees of the Association shall be fixed by the Council.

Sec. 11. The Council shall provide such headquarters for the Association as may be required to conduct its business properly.

Sec. 12. The Council shall be empowered to elect an Executive Secretary and Assistant Executive Secretary and such other personnel as may be necessary, who need not be members of the Missouri State Medical Association, each of whom shall perform such duties as the Council may designate and receive such salary and serve for such periods and under such conditions as the Council may determine.

CHAPTER VII. COMMITTEES AND COMMISSIONS

Section 1. Standing Committees of the Missouri State Medical Association, the chairman of which shall be appointed by the Association President unless otherwise provided in these Bylaws, will be as follows:

Executive Committee.
Committee on Constitution and Bylaws.
Committee on Publication.
Committee on Legislative Affairs.
Committee on Planning.
Committee on Voluntary Health Agencies.

The **Executive Committee** shall consist of the Association President, President-Elect, Secretary, Treasurer, Council Chairman and Council Vice-Chairman. The President of the Association shall be Chairman of the Executive Committee. The Executive Committee shall plan and execute such work as may be necessary for the welfare of the Association and the conduct of the Executive Secretary's Office between meetings of the Council, but shall be responsible at all times to the Council.

The Committee on **Constitution and Bylaws** shall consist of five members named by the President and shall propose such amendments to the Constitution and Bylaws as are deemed wise and expedient, and brin before the House of Delegates such amendments as i or other members of the Association may present fo consideration. The President shall appoint one membe for one year, two members for two years and two members for three years. As the term of each expires, hi successor shall be appointed for a term of three years.

The Committee on **Publication** shall consist of fiv members and be appointed annually by the Counc and shall be responsible for general publication an distribution policies of the Journal. The Editor of th Journal shall be designated by the Council and als shall serve as Chairman of the Committee on Publication. The Editor shall be empowered to nominate a Editorial Board, subject to approval by the Council The members of the Editorial Board will assist the Editor in soliciting, preparing and reviewing material fo publication in the Journal.

The Committee on **Legislative Affairs** shall consis of five members of the Association, appointed annuall by the President. The Committee shall consider legislative proposals affecting health problems of the peopl of the state and the practice of medicine and sha make recommendations to the Council and the Hous of Delegates as well as directing staff activities in suc matters.

The **Planning Committee** shall consist of ten members to be appointed by the President. Two member shall be appointed for one year, two for two years, tw for three years, two for four years and two for fiv years. As the term of each expires, his successor sha be appointed for a term of five years. In making suc appointments, the President shall be governed by experience of the member, the size of his medical society and his geographical area, so as to have a representative committee. Age of the members shall be considered to the end that one third to one half of th committee shall be of an age group that should contemplate ten to twenty years more of active practice.

The Committee on **Voluntary Health Agencies** sha consist of five members of the Association appointe by the President. Two members shall be appointed fo three years, two members for two years and one member for one year. As the term of each expires, his successor shall be appointed for a term of three years. Th Committee on Voluntary Health Agencies shall provid liaison and work with all voluntary health organizations.

Sec. 2. Standing Commissions of the Missouri Stat Medical Association, who shall be responsible to th Council and whose chairman shall be appointed by th Association President, will be as follows:

Commission on Public Affairs.

Commission on Medical Economics, Third Party and overnmental Relations.

Commission on Continuing Education and Health anpower.

Commission on Medical-Legal Affairs.

Commission on Interspecialty Medicine.

Subsection a. The standing Commissions, unless othrwise provided in these Bylaws, shall consist of fifteen embers serving three-year terms and the terms will e staggered so that the President will appoint five embers of each Commission each year. Initially, the resident will appoint five members to one-year terms, ve members to two-year terms and five members to hree-year terms and no member shall serve more than vo consecutive terms.

Subsec. b. The Chairman of each Commission may ppoint Ad Hoc Committees to carry out the Commision's programs. These Ad Hoc Committees may inlude any Missouri State Medical Association member.

Subsec. c. The Chairman of the Council shall apoint each year an appropriate Councilor to serve as dvisor to each respective Commission.

The Commission on **Public Affairs** shall plan and excute programs designed to enhance the relationship etween the public and the medical profession. The ommission shall have responsibility in the fields of inustrial health, environmental health, medicine and region, trauma, disaster medical care and national deense and other public matters.

The Commission on **Medical Economics, Third Party edicine and Governmental Relations** shall keep close aison and work with peer and utilization review mechnisms, insurance intermediaries and governmental gencies.

The Commission on **Continuing Education and ealth Manpower** shall determine the character and cope of the scientific proceedings of the Association or each annual session as well as to make all arrangements for such annual sessions, subject to the instrucions of the House of Delegates. The Commission shall lso be responsible for the entire continuing education rogram of the Association, shall have all matters peraining to hospitals referred to it, shall carry on all programs in the recruitment of health manpower in profesional as well as in allied health fields and shall be reponsible for programs in the rural health field.

The Commission on **Medical-Legal Affairs** shall inestigate and study medical-legal matters affecting the ractice of medicine, make recommendations to the ouncil and House of Delegates and also make certain hat all Association members are kept informed of imortant developments in this field. The Commission lso may work with similar groups formed by the State Bar Association on matters of joint interest and concern as well as with governmental and insurance agencies in this field.

The Commission on **Interspecialty Medicine** shall be composed of one representative of each statewide specialty group as recognized by the Association Council. The President of the Missouri State Medical Association shall appoint annually to the Commission a representative from each of the authorized groups as submitted to him by the specialty organization. In the event that such a nominee is not submitted to him by an organization, the Association President may designate a member of that specialty group to serve on the Commission.

The Commission shall be charged with the responsibility of reviewing organization problems with respect to scientific programs, socio-economic and legislative matters that affect their particular specialties; in addition the Commission shall have the responsibility for programs and activities in fields relating to disease and health services involving the citizens of our state and such other matters as the Council shall direct. Also, the Commission shall provide close liaison between the various specialty organizations and the Missouri State Medical Association.

Sec. 3. Fifty percent of a Committee or a Commission should be present at an official meeting to constiture a quorum.

Sec. 4. Special committees may be appointed by the President or the Council as circumstances may demand.

Chapter VIII. Dues and Assessments

Section 1. (a) The annual dues of this Association shall be $90.00, which shall be applicable to each active member of the Association beginning in 1975 and shall be levied per capita on the active members of the component societies; the per capita levy for junior members shall be $10.00 per year; honor and associate members shall not be required to pay dues. Dues shall be payable on January 1 of the year for which they are levied.

(b) An assessment of $10.00 per year on each active member of the Association shall be applicable for a three-year period beginning in 1975. The assessment shall be payable with the dues of the Association, and the monies collected therefrom shall be remitted to the Missouri State Medical Foundation.

Sec. 2. Three dollars of the annual dues shall be credited to the account of the Journal for each member's annual subscription. The remainder of the amount shall be credited to the general fund of the Association.

Sec. 3. The House of Delegates may, when in its judgment the best interest of the Association demands, recommend an assessment on each active and junior member. Such assessment shall be levied only by consent of two thirds of the members of the House of Delegates present and voting. Funds obtained from such special assessment shall be allocated only for the purposes for which such assessment is levied and in accordance with substantiating budgets. Unexpended balances from such assessments must be reported to the House of Delegates for re-allocation.

Sec. 4. The secretary of each component society shall cause to be collected and remitted to the Treasurer of this Association the per capita levies. Any member whose name has not been reported for enrollment and whose dues have not been remitted to the Treasurer of this Association on or before March 1 shall stand suspended until his name is properly reported and his dues for the current year are paid. On December 31 of each year, members delinquent in payment of dues, and assessment if such has been made, or any part thereof shall, ipso facto, forfeit their memberships. No suspended member shall be eligible to register at an annual session.

CHAPTER IX. RULES OF CONDUCT

The ethical principles governing the members of the American Medical Association shall govern members of this Association.

CHAPTER X. RULES OF ORDER

The deliberations of this Association shall be conducted in accordance with parliamentary usages as defined in *Sturgis Standard Code of Parliamentary Procedure.*

CHAPTER XI. COUNTY SOCIETIES

Section 1. All county societies now in affiliation with the State Association or those that may hereafter be organized in this state, which have adopted principles of organization not in conflict with this Constitution and Bylaws shall, upon application to the Council, receive charters from this Association provided that their Constitutions and Bylaws shall have been submitted to the Council and received its approval.

Sec. 2. Only one component medical society shall be chartered in each county.

Sec. 3. Each county society shall be judge of the qualifications of its members, subject to review and final decision by the Council of the State Association. Every reputable and legally qualified physician who does not practice, nor profess to practice sectarian medicine, and who resides or practices in the same county, who shall apply for membership on the prescribed form and subscribe for the Journal and pay the annual dues and assessments for the current year, shall be eligibl for election to membership.

A member of a component society whose license ha been revoked shall be dropped from membership automatically as of the date of revocation. The Counci of the State Association shall have final authority t expel a member should a component county society fai to do so after being so requested by the Council.

The Council may upon request of a component society remit the state dues and assessment of a membe who has become totally and permanently incapacitate through mental or physical disability and has been ember in good standing during the three consecutiv years immediately preceding his disability; provided that the component society shall remit the county society dues of such member.

The Council may, upon request of a component society, remit the state dues and assessments of a deserving member, found to fall within what is classified a a hardship case, during the period of said hardship until such time as the dues again become payable; provided that the component society shall remit the count society dues of such member.

The Council may, upon the request of a componen society, waive the dues of any member in good standing for such a period as the member is serving in th Armed Forces of the United States of America, or similar services with any of the allies of the United States and for six months thereafter.

A physician living near a county line may hold hi membership in that county most convenient for him t attend, on permission of the component society i whose jurisdiction he resides.

Sec. 4. Any physician who may feel aggrieved b the action of the society of his county in suspending o expelling him shall have the right to appeal to th Council whose decision shall be final. A county societ shall at all times be permitted to appeal or refer questions involving membership to the Council of the Stat Association for final determination.

Sec. 5. In hearing appeals the Council may admi oral or written evidence or both as in its judgment wil most fairly present the facts.

Sec. 6. When a member in good standing in a component county society moves to another county in thi state, he shall be given a written certificate of thes facts by the secretary of his society, without cost, fo transmission to the secretary of the society in the county to which he moves. Pending his acceptance or rejection by the society in the county to which he move such member shall be considered to be in good standing in the county society from which he was certifie nd in the State Association to the end of the period or which his dues have been paid.

A member of a component society who moves to and ngages in the practice of medicine at a location in anther county in which there is a component society hall forfeit his membership in this Association and the ecretary shall remove his name from the roster of nembers of the Missouri State Medical Association uness within one year after such change of residence he ecomes a member of the component society in the ounty to which he has moved.

Sec. 7. Each county society shall have general diection of the affairs of the profession in the county, nd its influence shall be constantly exerted for betterng the scientific, moral and material condition of every hysician in the county. Systematic efforts shall be nade by each member, and by the society as a whole, o increase the membership until it includes every eliible physician in the county.

Sec. 8. At some meeting in advance of the Annual ession of this Association, each component county soiety shall elect one or more delegates and an equal umber of alternates therefor to represent it in the Iouse of Delegates of this Association, in accordance vith Chapter III, Section 2 of these Bylaws. The secetary of each county society shall send a list of such lelegates and alternates to the Secretary of this Assoiation at least sixty days before the Annual Session. epresentation in the House of Delegates shall be coningent on compliance with the foregoing provisions.

Sec. 9. The secretary of each county society shall eep a roster of its members and, if practicable, a list of non-affiliated physicians, in which shall be shown the full name, address, college and date of graduation, date of license to practice in this state, and such other information as may be deemed necessary by the Council. He shall send a copy of the program of each meeting to his district councilor and to the Secretary of the State Association.

Sec. 10. Any county component society, in a manner approved by the State Association, or the State Association with the consent of the county society or societies affected, may undertake, organize and put into effect plans for the medical care of indigent persons or indigent groups, and low income groups, by agreements with physicians, public officials or others and by the use of contributions, cooperative funds or other means; provided, however, that a free choice of the available and participating physicians in that territory shall be allowed to the patient and that all relationships, legal or otherwise, between the physician and the patient shall be and remain as though it were strictly an individual employment.

Chapter XII. Amendments

Section 1. These Bylaws may be amended at any Annual Session by a two-thirds vote of the delegates present and voting at that session, if the proposed amendment has been properly submitted to the House of Delegates and has laid on the table for one day.

Sec. 2. Upon the adoption of this Constitution and these Bylaws all previous constitutions and bylaws are thereby repealed.

Neumann, James W., 2929 Baltimore 64108
Newman, Robert L., Wornall Rd. at 44th 64111
Nigro, E. Robert, 2901 Tomahawk Rd., Shawnee Mission, Kan. 66207
Nigro, Joseph A., 1226 W. 62nd 64113
Noback, Richardson K., 2200 Holmes 64108
Noltensmeyer, Milton N., 3305 W. 50th Terr., Shawnee Mission, Kan. 66205
Novak, Edward J., 3011 Baltimore 64109
O'Farrell, Thomas P., 6400 Prospect 64132
O'Hearne, John J., 4706 Broadway 64112
O'Kell, Richard T., Wornall Rd. at 44th St. 64111
O'Malley, James F., 6700 Troost 64131
O'Neil, James H., 9120 W. 72nd, Shawnee Mission, Kansas 66204
Osborne, Jere O., 644 W. 69th Terr. 64113
Ost, Mark D., 6700 Troost 64131
Overesch, Harry B., 6400 Prospect 64132
Owens, James L., 920 W. 47th 64112
Owens, Richard L., 207 W. 116th 64114
Owens, Robert H., 6700 Troost 64131
Ozar, Milton B., 6700 Troost 64131
Pack, Gary L., 751 E. 63rd 64110
Pakula, Sidney F., 10839 State Line 64114
Parelman, Allen G., 601 E. 63rd St. 64110
Parker, Hubert M., Suite 435, 2929 Baltimore Ave. 64108
Parsons, Eugene O., 145th & State Line, Kenneth Rd., Stanley, Kan. 66224
Pawsat, John E., 4320 Wornall Rd. 64111
Pearson, Paul E., 102 E. 51st 64112
Pecoraro, Anthony P., 4320 Wornall Rd. 64111
Peete, Don C., Professional Bldg. 64106
Pelegrin, Robert J., 17221 E. 23rd, Independence 64057
Pemberton, L. Beaty, 2411 Holmes 64108
Penner, Stanley, 601 E. 63rd St. 64110
Perll, Maurice F., 6700 Troost 64131
Perll, Rita D., 830 W. 61st Terr. 64113
Perry, Ralph, 6400 Prospect 64132
Petersen, Eugene G., 108 Hackberry, Lee's Summit 64063
Peterson, Bonita J., 4525 Holly 64111
Peterson, Carl M., 2701 E. 31st St. 64128
Peterson, George L., 315 Nichols Rd. 64112
Peterson, Walter R., 2701 E. 31st St. 64128
Petit, Carl A., 4620 J. C. Nichols Pkwy. 64112
Petry, Ezra L., 13740 W. 90th Pl., Lenexa, Kans. 66215
Pickard, Nicholas S., 6210 High Dr., Shawnee Mission, Kan. 66208
Pickering, Lee I., 1515 W. Truman, Independence 64050
Piebenga, Larry W., 2928 Main 64108
Piepergerdes, Larry G., 701 Blue Ridge Tower, 4240 Blue Ridge Blvd. 64133
Pinkerton, Joseph A., Jr., 4320 Wornall Rd. 64111
Pinsker, Oscar T., 6724 Troost 64131
Piper, Donald K., 6700 Troost 64131
Pipkin, Garrett F., Rt. 2, Clinton 64735
Place, K. Craig, St. Luke's Hospital 64141
Politi, Gregory, 31st & Wyandotte 64108
Pollock, Leo H., 751 E. 63rd St. 64110
Poonawala, Huseni E., 6301 Rockhill Rd. 64131
Pope, Charles H., Jr., 8800 E. 63rd 64133
Porter, Louis, 751 E. 63rd St. 64110
Porter, Michael J., 751 E. 63rd 64110
Potter, Lee G., 5000 Oak 64112
Potts, Donald A., 110 E. 23rd, Independence 64055
Powell, Alan E., 17221 E. 23rd, Independence 64057
Powell, Nelson E., Wornall Rd. & 44th 64111
Powers, John M., 3838 Blue Ridge Blvd., Independence 64052
Printz, Joseph H., 601 E. 63rd St. 64110
Printz, Otto J., 601 E. 63rd St. 64110
Pucci, Gregory L., 411 Nichols Rd. 64112
Pugh, Richard G., 1612 W. Truman Rd. Independence 64050
Quer, Erich A., 6400 Prospect 64132
Racela, Antonio S., Jr., Linwood at Prospect 64128
Rader, Ada B., 13414 Locust St. 64145
Raich, Robert A., 4320 Wornall Rd. 64111
Ramey, Ehret O., 4320 Wornall Rd. 64111
Ramos, Americo G., 6700 Troost 64131
Rannie, Paul R., 709 S. Fuller St., Independence 64052
Ratnam, Dasari V., 11962 Pennsylvania 64145
Rauck, James E., 4706 Broadway 64112
Ravis, Mark S., 1734 E. 63rd 64110
Rector, Joe L., Jr., St. Luke's Hosp. 64111
Reddin, Jack L., 17221 E. 23rd, Independence 64057
Reed, Wm. A., 4320 Wornall Rd. 64111
Reinhardt, George R., 6400 Prospect 64132
Reiss, Jeanne E. L., 751 E. 63rd. 64110
Reister, Dorothy D., 5201 W. 84th, Shawnee Mission, Kan. 66207
Reister, Philip D., 701 E. 63rd 64110
Rengachary, Dhanalakshmi, 825 Euclid 64124
Reynolds, Clarence C., 3129 Swope Parkway 64130
Rhoades, Arthur B., P.O. Box 4828, Shawnee Mission, Kan. 66204
Rhodes, Andrew J., 6724 Troost, Suite 304 64131
Rhodes, Philip G., 24th & Gillham 64108
Ricci, Walter F., 6724 Troost, Suite 205 64131
Richany, Shafik F., 24th & Cherry 64108
Richardson, Marion W., 2526 Prospect 64127
Richert, Robert C., 504 W. 96th 64114
Riekhof, Paul L., 4320 Wornall Rd. 64111
Riley, Joseph P., Jr., Parthenon, Ark. 72666
Riller, Lowell E., Professional Bldg. 64106
Rippey, John H., Wornall Rd. at 44th 64111
Roberts, Grosvenor G., 777 N. Blue Parkway, Lee's Summit 64063
Roberts, Harold M., 4618 Warwick 64112
Robinett, Wade V., 6700 Troost 64131
Robinson, Arthur W., 4320 Wornall Rd. 64111
Robinson, E. Kip, 1015 W. 58th Terr. 64113
Robinson, William J., 601 E. 63rd St. 64110
Robles, Luis H., 777 N. Blue Parkway, Lee's Summit 64063
Rodgers, George H., 10041 El Monte Lane, Overland Park, Kan. 66207
Rodgers, Samuel U., 2701 E. 31st St. 64128
Rodriquez, Rolando A., 5012 Reinhardt Ave., Shawnee Mission, Kan. 66205
Rofail, Amin A., 9206 England, Shawnee Mission, Kan. 66212
Rogers, Robert L., 6724 Troost 64131
°Romito, Anthony J., 5529 Troost 64110
Rose, Charles W., 334 S. Van Brunt 64124
Roth, Alfred, 6700 Troost 64131
Rozen, Jay I., 6400 Prospect 64132
Rubin, Harvey P., 701 E. 63rd 64110
Rubnitz, Leon H., 751 E. 63rd St. 64110
Rufe, John R., 2928 Main 64108
Russell, James C., 9406 E. 63rd 64133
Russell, James L., Suite 420, 2929 Baltimore Ave. 64108
Russell, Robert K., 63rd & Evanston, Raytown 64133
Sabates, Felix N., 6700 Troost 64131
Saferstein, A. Lester, 6859 Cherry 64131
Saladino, Anthony, 2009 W. 67th, Shawnee Mission, Kan. 66208
Samuelson, Edward A., 4620 Nichols Parkway 64112
Sanders, Donald C., 411 Nichols Rd. 64112
Sanders, Harmon U., Jr., 115 Humphrey, Greenwood, Miss. 38930
Sanders, William F., 411 Nichols Rd. 64112
Sandow, Theodore L., Jr., 4320 Wornall Rd. 64111
Santoro, Carlos G., 1103 Westport Rd. 64111
Santschi, Don R., 2220 Holmes 64108
Sauer, Gordon C., 6400 Prospect Ave. 64132
Scales, Margaret B., 6700 Troost 64131
Schaerrer, William C., 4320 Wornall Rd. 64111
Schiffmacher, Jack E., 1212 South 10th, Blue Springs 64015
Schillie, Gene A., 6400 Prospect 64132
Schlozman, Daniel L., Meyer Blvd. at Prospect, Level A 64132
Schmidt, C. Robert, 10236 Bunker Ridge Rd. 64137
Schoolman, Arnold, 6700 Troost 64131
Schottman, Gerhard W., Jr., St. Luke's Hosp. 64111
Schuman, Norvin D., Meyer Blvd. at Prospect 64132
Schutz, Carl B., 841 San Pablo Dr., San Marcos, Calif. 92069
Schutz, Richard B., 603 A Lilac Place, Lee's Summit 64063
Scott, John E., 10901 Winner Rd., Independence 64052
Seely, Clark W., 3000 W. 68th, Shawnee Mission, Kan. 66208
Seiden, Gerald D., 6724 Troost 64131
Seitz, Elson F., 1509 W. Truman Rd. 64050
Sells, Kenneth J., Suite 310, 2929 Baltimore Ave. 64108
Shalet, Malcolm F., 6724 Troost 64131
Shalley, Jack E., 4240 Blue Ridge Blvd. 64133
°Shank, Neil A., 701 E. 63rd 64110
Shapiro, Lazare M., 701 E. 63rd St. 64110
Sheahon, John A., 6700 Raytown Rd. 64133
Shechter, Nathan, 601 E. 63rd 64110
Shelden, Russell D., 6400 Prospect 64132
Shen, Yen, Little Blue & Lee's Summit 64139
Shifrin, Alexander, 6700 Troost 64131
Shockley, Clarence J., 418 Winnebago Dr., Greenwood 64034
Shuey, Herbert H., 3 E. Gregory 64114
Shypper, Moses J., 13527 Crewe St., Van Nuys, Calif. 91405
Siegel, Carl, VA Hospital, 4801 Linwood 64128
Simmons, Donald D., 4301 Main 64111
Simmons, John L., 6400 Prospect 64132
Simon, Sanford, 751 E. 63rd St. 64110
Sinclair, Richard H., 4320 Wornall Rd., Suite 308 64111
Singleton, Chas. M., II, 4320 Wornall Rd. 64111
Singleton, John M., III, 411 Nichols Rd. 64112
Sirridge, Marjorie S., 2411 Holmes 64108
Sirridge, Wm. T., 24th & Cherry 64108
Skillman, Robert K., 4320 Wornall Rd. 64111
Skinner, John T., Bryant Bldg. 64106
Slankard, Edward, 4320 Wornall Rd. 64111
Slentz, Edwin L., 4320 Wornall Rd. 64111
Slentz, William A., 4320 Wornall Rd. 64111
Slickman, R. A., 2929 Baltimore 64108
Smith, Arthur B., 6400 Prospect Ave. 64132
Smith, Elbert E., III, 4320 Wornall Rd. 64111
Smith, H. Eugene, 411 Nichols Rd. 64112
Smith, Ira T., 6400 Prospect 64132
Smith, James M., 21 W. 43rd 64111
Smith, John C., 24th & Cherry 64108
Smith, Katherine W., 24th & Gillham Rd. 64108
Smith, O. D., 6700 Troost 64131
Smith, Wallace B., 1515 W. Truman Rd., Independence 64050
Smull, Ned W., 24th & Gillham Rd. 64108
Sneid, Philip, 701 E. 63rd St. 64110
Snider, Wilbur R., 24th & Cherry 64108
Soper, Steven J., 1505 W. Truman Rd., Independence 64050
Spafford, Allen L., 315 Nichols Rd. 64112
Spalding, Wilber B., Jr., 2928 Main 64108
Spencer, Donald M., 4240 Blue Ridge Blvd. 64133
Spies, Barbara J., 11201 Colorado 64137
Sprinz, Helmuth, 24th & Cherry 64108
Spurney, Joe E., 11201 Colorado 64137
Spurny, Otto M., 6724 Troost 64131
Stacey, Wallace R., 2116 S. Sterling Ave., Independence 64052
Staggs, William A., Suite 335, 2929 Baltimore Ave. 64108
Staley, Harry R., 4740 Roaonke Pkwy. 64112
Stanley, John H., 6301 Rockhill Rd. 64131
Statland, Harry, 601 E. 63rd St. 64110
Statland, Morris, 601 E. 63rd St. 64110
Steffen, Lawrence F., 411 Nichols Rd. 64112
Stegman, Elmer G., 6137 Blue Ridge Blvd., Raytown 64133
Stelle, Charles W., 4304 W. 82nd Terr., Prairie Village, Kan. 66208
Stelmach, Walter J., Baptist Memorial Hospital, 6601 Rockhill Rd. 64131
Stephens, Jack D., 751 E. 63rd 64110
Stern, Thomas L., 1740 W. 92nd 64114
Stewart, Harry A., 4706 Broadway 64112
Stockton, Raymond W., 4320 Wornall Rd. 64111
Stockwell, A. Lloyd, 24th & Cherry 64108
Stotts, Charles S., R.R. 4, Fredonia, Kan. 66736
Stratemeier, Edward H., 31st & Wyandotte 64108
Strauss, Carl F., 8300 Troost 64131
Stribling, Thomas L., 2116 S. Sterling Ave., Independence 64052
Stromberg, Eric D., 6400 Prospect 64132
Stuber, Jack L., 24th & Cherry 64108
Suddarth, Sterling B., 4240 Blue Ridge Blvd. 64133
Sumathy, Vannarth, 2933 Baltimore 64108
Suseela, Dasari, 2310 E. Linwood Blvd. 64109
Sutton, Richard L., Jr., 4121 W. 83rd Shawnee Mission, Kan. 66208
Swisher, Robert C., 2209 Ptarmigan Dr. #4, Walnut Creek, Calif. 94595
Switzer, Clyde, 8100 W. 54th Terr., Overland Park, Kan. 66202
Sword, Richard O., 800 W. 47th St. 64110

° Doctor of Osteopathy.

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Tamblyn, Claire L., 6400 Prospect 64132
Tarson, Solomon S., 5511 W. 85th St., Overland Park, Kan. 66207
Tasker, Charles B., 11083 Burntwood Dr., Sun City, Ariz. 85351
Taylor, Loren F., 5535 N. Camino Real, Tucson, Ariz. 85718
Tesson, James A., 9911 Lee Blvd., Shawnee Mission, Kan. 66206
Thalblum, Harvey, 6400 Prospect 64132
Theel, Otto W., Jr., 4301 Main 64111
Thiele, George H., 1219 West 48th 64112
Thomas, Christopher Y., 4320 Wornall Rd. 64111
° Thomas-Richards, Jose R., 44th & Wornall 64111
Thompson, Charles L., 4320 Wornall Rd. 64111
Throne, Bennie J., 6400 Prospect 64132
Throne, Elias M., Meyer Blvd. & Prospect 64132
Tice, Wayne K., 3504 S. Delaware, Independence 64055
Tillema, David A., 6306 Morningside 64113
Tiojanco, Milagros E., 6601 Rockhill Rd. 64131
Tiojanco, Reynaldo R., 5801 E. 113th St. 64134
Titterington, Frank W., 44th & Wornall 64111
Tokrisna, Apbiraks, 10901 Winner Rd., Independence 64052
Totten, Frederick E., 9331 Hayes Dr., Overland Park, Kan. 66212
Toubes, Daniel B., 8300 Troost 64131
Trimble, George X., 101 Memorial Dr. 64108
Troeh, Melvin R., 1515 W. Truman Rd., Independence 64050
Trowbridge, Barnard C., 415 E. 63rd St. 64110
Trowbridge, Ellsworth H., Jr., 411 Nichols Rd. 64112
Tuohy, Gerald F., 9725 Shepherd's Dr. 64131
Turano, William L., 6700 Raytown 64133
Turner, Ronald M., Suite 402, 1515 W. Truman Rd., Independence 64050
Tutera, Dominic F., Plaza Medical Bldg. 64112
Tutera, Gino, 11055 Cedar, Shawnee Mission, Kan. 66211
Tuthill, Herbert, 202 S. Cook, Barrington, Ill. 60010
Twin, Edward J., 24th & Cherry 64108
Twyman, Richard A., 4320 Wornall Rd. 64111
Underwood, Dick H., 6700 Troost 64131
Upsher, Albert E., Box 2778, 64106
Valins, Eugene, 1815 E. 63rd. 64130
Van Biber, James T., 1612 W. Truman Rd., Independence 64050
Van Buskirk, Terrance E., 5246 St. John 64123
Van Buskirk, William C., 6700 Troost 64131
Van Hook, David, 4320 Wornall 64111
Van Thullenar, Philip A., 4949 Rockhill Rd. 64110
Vaughn, James W., 4635 Wyandotte 64112
Venegoni, Robert L., 6700 Troost 64131
Vera, Enrique, 6724 Troost, Suite 205 64131
Vergara, Gerardo G., 5200 W. 84th Terr., Shawnee Mission, Kan. 66207
Victor, Frank R., 701 E. 63rd 64110
Vidals, Victor G., 7540 Troost 64131
Vincent, Jack C., 8300 Troost 64131
Virden, Herbert H., 6700 Troost 64131
Viril, Leonardo C., 4706 Broadway 64112
Vogel, Arthur P., 2215 Drury La., Shawnee Mission, Kansas 66208
Volk, George E., 109 W. 115th 64114
Voth, Harold W., 4320 Wornall Rd. 64111
Wade, Frederick E., Professional Bldg. 64106
Wagner, Paul J., Trinity Hospital 64108
Wakefield, Franklin H., 13065-100th Dr., Sun City, Ariz. 85351
Waldman, Richard A., 24th & Gillham 64108
Walker, James C., 2727 Main 64108
Walker, John W., 6400 Prospect 64132
Walker, Orville C., Jr., 10901 Winner Rd. Independence 64052
Wall, Harry C., 751 E. 63rd St. 64110
Wall, Leonard A., 4320 Wornall Rd. 64111
Wally, John W., P.O. Box 8173, 64112
° Wang, George Y. M., R.F.D. 2, Box 248D, Belton 64012
° Wasserman, Gary S., 24th & Gillham Rd. 64108
Wathanacharoen, Suchint, 4320 Wornall Rd. 64111
Watson, Ethel, 1539 Evanston, Independence 64052
Waxman, Herbert J., 8300 Troost 64131
Waxman, Jane Z., 4840 Prospect 64130
Webb, Harry E., 330 W. 47th St. 64112
Weidmaier, Edward J., 2929 Baltimore 64108
Weiford, Edward C., 4320 Wornall Rd. 64111
Weir, Robert K., 4240 Blue Ridge Blvd. 64133
Wells, Donald E., Meyer Blvd. at Prospect 64132
Wells, James A., 3717 Bell 64111
Wells, John H., 3325 Prospect 64128
Wenner, Herbert A., 24th & Gillham 64108
West, Harold, 1734 E. 63rd 64110
Wheeler, Charles B., 830 W. 53rd 64111
Wheeler, John H., 4320 Wornall Rd. 64111
White, Charles H., 6700 Troost 64131
White, James S., 751 E. 63rd 64110
White, Stoughton F., 4320 Wornall Rd. 64111
White, William E., 6400 Prospect 64132
Whiteman, John R., Suite 545, 2929 Baltimore Ave. 64108
Whitman, Doyle C., 6836 Cherokee La., Shawnee Mission, Kan. 66208
Whitmore, J. Stewart, Suite 340, 2929 Baltimore Ave. 64108
Whittaker, Charles K., 4440 Broadway 64111
Whitten, John S., 2116 Sterling, Independence 64052
Wicks, Edwin O., 506 N.W. 43rd 64116
Wien, Irving A., 1103 Grand 64106
Wilber, Robert D., 4320 Wornall Rd. 64111
Wilhelm, Warren F., 6400 Prospect 64132
Wilkinson, Charles B., 4604 Benton Blvd. 64130
Wilkinson, Everett A., 6400 Prospect 64132
Williams, Frank R., 4320 Wornall Rd. 64111
Williams, George P., 10928 Hillcrest 64134
Williams, Joseph C., Jr., 6400 Prospect 64132
Williams, Roland D., 305 W. 43rd St. 64111
Williams, Starks J., 5600 Agnes 64130
Williams, Thomas, 9601 Manor Rd., Leawood, Kan. 66206
Willoughby, James W., 1125 Grand 64106
Willoughby, Jean B., 6400 Prospect 64132
Wilson, Clifford C., 102 E. 51st 64112
Winer, Herbert J., 6724 Troost 64131
Winer, Nathaniel, 24th & Cherry 64108
Winkelman, Esther B., 6400 Prospect 64132
Winston, Bernard H., 601 E. 63rd St. 64110
Wise, George W., 24th & Gillham Rd. 64108
Wise, Morris F., Suite 274, 751 E. 63rd 64110
Withers, Orval R., Plaza Parkway Bldg. 64112
Woehl, Joseph J., 620 Medical Plaza 64111
Wolf, Jack W., 6724 Troost 64131
Woodman, Grey M., 600 E. 22nd 64108
Woods, Harold V., 1405 W. 40 Hwy., Blue Springs 64015
Woods, S. Dwight, 4320 Wornall Rd. 64111
Woods, Walton C., TWA Overhaul Base, P.O. Box 20126, 64195
Woodward, William W., 3537 Broadway 64141
Wortmann, Robert F., 6400 Prospect 64132
Wright, R. Paul, 6700 Troost 64131
Wu, Shuh-Min, 6724 Troost 64131
Wu, William Q., 6700 Troost 64131
Wurster, Jerry B., 4320 Wornall Rd. 64111
Wurster, W. Joel, 305 W. 43rd St. 64111
Youll, Donald V., 6700 Troost 64131
Youmans, Ronald A., 415 E. 63rd St. 64110
Young, James E., 716 Medical Plaza 64111
Young, Jesse W., 1401 Southwest Blvd., Kansas City, Kan. 66103
Youngblood, James P., 4620 Nichols Parkway 64112
Zacharias, David L., St. Joseph Hosp., Linwood Blvd. at Prospect 64128
Zahony, Ivan, 8720 Rosewood, Prairie Village, Kan. 66207
Zahorsky, Carroll L., 230 Penn Park Medical Center 64108
Zellermayer, Jacob, 5801 Lockton La., Shawnee Mission, Kan. 66205
Zinn, Marsha V. E., 44th & Wornall 64111
Zoller, David D., 101 Memorial Dr. 64108
Zwerenz, Bruno H., 1734 E. 63rd St. 64110

JASPER COUNTY MEDICAL SOCIETY
(Joplin)

Adams, Robert B., Jr., 3103 McClelland 64801
Allen, David O., 3105 McClelland 64803
Bentlage, Charles H., 25th & Jackson 64801
Bbend, David P., Medical Arts Bldg. 64801
Birsner, Frank H., 2410 Jackson St., 64801
Bladow, Terrence C., 3107 McClelland 64801
Bopp, Jon Ronald, 505 Glenview 64801
Brandon, Fredrick M., 2008 Sergeant 64801
Burcb, John E., P.O. Box 2006 64801
Burleigh, Bruce W., 2700 McClelland Blvd. 64801
Butler, Patrick L., Box 280, Diamond 64840
Carnes, Victor M., P.O. Box B, Main Office 64801
Chase, Ned B., Jr., 2700 McClelland 64801
Chesney, George W., 2604 Picher 64801
Clark, Frank I., III, 3107 McClelland Blvd. 64801
Cohle, Richard R., Carthage 64836
Craig, Irwin T., 3209 McClelland 64801
Crawford, Archie L., Frisco Bldg. 64801
Crispell, Lawrence S., 6th & Pearl 64801
Davis, Charles S., 301 Medical Arts Bldg. 64801
DeTar, Burleigh E., 410 Jackson 64801
Eliscu, Juliette M., 2002 Jackson 64803
Esther, John R., Ferguson's Med. Laboratories 64801
Ferguson, Lewis H., Jr., 315 Sweetbriar Dr., Alexandria, La. 71301
Ferguson, Ralph L., P.O. Box B, 64801
Ferguson, Robert M., 2015 Jackson 64801
Fritsch, Andrew J., 2920 Pearl 64801
Gardner, Joseph A., 3209 McClelland Blvd. 64801
Gaston, Samuel Lee, 101 Medical Arts Bldg. 64801
Grim, Edward M., 3105 McClelland Blvd. 64801
Grubb, Paul H., 2509 Jackson 64803
Hall, Marvin F., Medical Arts Bldg. 64801
Hallaba, M. A. S., 25th & Jackson 64801
Hamilton, Eugene H., 2017 Jackson 64801
Hilton, Paul E., 1612 Murphy Blvd. 64801
Holtzman, Samuel, 3001 M. L. King Dr., Apt. 201, Chicago, Ill. 60616
Hurst, Wilfred W., Medical Arts Bldg. 64801
Hwang, Yung H., 1515 Hazel Ave., Carthage 64836
Isbell, Cbarles H., Carthage 64836
Jeans, Virgil, 660 Jaccard Pl. 64801
Kirkman, Robert E., 2529 Jackson 64803
Koehler, John W., 3103 McClelland Blvd. 64801
Kubn, John R., Jr., Frisco Bldg. 64801
Longenecker, Joe L., 2503 Jackson 64803
McGonigle, James P., 718 Illinois 64801
McKee, Howard B., Medical Arts Building, #206 64801
McPike, Lloyd H., 2401 Jackson 64801
MacLaughlin, James C., 3103 McClelland 64801
Manalo, Gil Baleva, Jr., 1320 S. Main, Carthage 64836
Martin, Clarence A., 2419 E. 10th 64801
Mueller, Adolph R., Jr., 2700 McClelland 64801
Paddock, Charles S., 3905 Rangeline 64801
Patterson, Donald R., 2509 Jackson 64803
Patterson, Grover S., 510 S. Main, Carthage 64836
Pence, F. Wendell, 612 S. Main, Carthage 64836
Poor, Carl W., Rt. 1, Box 302, Neosho 64850
Post, Winfred L., 2630 E. 15th 64801
Powell, Robert G., 2329 Jackson 64803
Pryor, Ira J., 2700 McClelland 64801
Roberts, Howard H., 3209 McClelland 64801
Royce, James J., Sarcoxie 64862
Schmidt, Herbert J., 3912 Shaccoree, Durham, N.C. 27705
Schoeberl, Cletus B., Medical Arts Bldg. 64801
Schulte, Gregory A., 2125 Jackson 64803
Scorse, Sidney W., 619 W. 2nd 64801
Shanahan, Mary P., P.O. Box 2125 64801
Singleton, Marvin A., 114 W. 32nd 64801
Smith, Roland T., Medical Arts Bldg. 64801
Smith, W. Russell, 211 E. Chestnut, Carthage 64836
Straub, David L., 3107 McClelland 64801
Vinson, Harold A., 4242 S. Oswego, Tulsa, Okla. 74135
Vinyard, Jack L., 2727 McClelland Blvd. 64801
Walker, Paul W., Medical Arts Bldg. 64801

° Doctor of Osteopathy.

Whitten, M. Foster, 616 W. Centennial, Carthage 64836
Wieman, Harry K., Medical Arts Bldg. 64801
Wilcox, Ruth E., 614a Joplin St. 64801
Willcoxon, Robert L., Medical Arts Bldg. 64801
Wilson, Alice H., Rt. 1, Box 163, Neosho 64850
Wood, George H., 1515 Hazel, Carthage 64836
Young, Calvin C., Jr., Medical Arts Bldg. 64801

JEFFERSON COUNTY MEDICAL SOCIETY

Albano, Benjamin I., 114 Mississippi Ave., Crystal City 63019
Allbee, Roger H., Crystal City 63019
Bai, Sangzin, 233 Main St., Festus 63028
Blank, Michael K., Rt. 3. DeSoto 63020
Bonifacio, Andres, 121 Mississippi Ave., Crystal City 63019
Carron, Joseph F., 1611 Hobelman, Arnold 63010
Deles, Vicente D., Crystal City 63019
Donnell, Harold E., De Soto 63020
Donnell, Robert H., Crystal City 63019
Donnell, Thomas A., De Soto 63020
Edwards, Waldo B., 135 W. Adams Ave., Kirkwood 63122
Judge, Walter T., Crystal City 63019
Kang, Chang H., 105 Easton Ave., De Soto 63020
Mayfield, James L., Crystal City 63019
Navato, Jose, 938 Brookvale Terr., Manchester 63011
Park, Duk Jae, 106 N. Mill St., Festus 63028
Rutledge, John F., Festus 63028
Sirintrapun, Seyvee, 1588 Westvale Dr., Festus 63028
Verzola, Eufemio, Rt. 5, Box 26, Festus 63028
Yoskit, Harry, Festus 63028

JOHNSON COUNTY MEDICAL SOCIETY
(Warrensburg 64093)

Cooper, R. Lee, Warrensburg
Cooper, Robert S., II, 122 E. Market, Warrensburg
Damron, Oscar H., Warrensburg
Folkner, A. L., Warrensburg
Gonzalez, M. Garza, Warrensburg
Grove, Gulph W., Knob Noster 65336
Hanna, Hugh A., Warrensburg
Harkness, Harry, 331 Hanover Arms Ct., Winston-Salem, N. C. 27104
Hobbs, George H., Warrensburg
Johnson, Charles S., Warrensburg
Jones, Keith D., Warrensburg
Lederer, Charles M., Warrensburg
Maxson, T. Reed, Warrensburg
Ragland, Jerry, Box 516, Warrensburg
Reynolds, M. Wayne, P. O. Box 86, Warrensburg

KNOX COUNTY
(North Central Counties Medical Society)

LACLEDE COUNTY
(Mid-Missouri County Medical Society)

LAFAYETTE-RAY COUNTY MEDICAL SOCIETY

Baik, Kil Y., Waverly 64096
Baldwin, Theodore R., 1236 Jesse James Rd., Excelsior Springs 64024
Best, Robert, 9127 Riggs, Apt. 3, Overland Park, Kan. 66212
Boydston, Catherine, Odessa 64076
Boydston, W. Wayne, Odessa 64076
Brady, Hugh S.. Concordia 64020
Cook, Thomas B., Richmond 64085
Cope, Joseph S., Lexington 64067
Crayton, Billy G., Waverly 64096
Crozier, Franklin A., Richmond 64085
Davault, George K., Richmond 64085
Goldberg, Isadore E., Braymer 64624
Kelling, Jordan, Waverly 64096
LaHue, William C., 1901 Sleepy Hollow Dr., Lexington 64067
McFadden, Gene A., Waverly 64096
Meyer, Jerry L., 834 Main St., Concordia 64020
Pavlu, Robert R., Waverly 64096
Riley, Charles T., Richmond 64085
Vajaranant, Manit, Medical Clinic, Lexington 64067
Ward, Joe, Lexington 64067
Williams, John W., Oak Grove 64075

LAWRENCE COUNTY
(Ozarks Medical Society)

LEWIS-CLARK-SCOTLAND COUNTIES MEDICAL SOCIETY

Davis, Landis Y., Canton 63435

LINCOLN COUNTY
(St. Charles-Lincoln County Medical Society)

LINN COUNTY
(Grand River Medical Society)

LIVINGSTON COUNTY
(Grand River Medical Society)

McDONALD COUNTY
(Ozarks Medical Society)

MACON COUNTY
(Chariton-Macon-Monroe-Randolph County Medical Society)

MADISON COUNTY
(Mineral Area County Medical Society)

MARIES COUNTY
(Mid-Missouri County Medical Society)

MARION-RALLS-SHELBY COUNTY MEDICAL SOCIETY
(Hannibal 63401)

Avila, Estrella Z. 110 Magnolia Ave.
Avila, Patricio, 110 Magnolia Ave.
Bach, Lysle M., 4209 W. Ely Rd.
Buben, Robert W., 2910 St. Mary's Ave.
Burns, Francis R., Tower Plaza, Clinic Rd.
Burton, Dale F., P.O. Box 311
Clisham, John F., B & L Bldg.
Comer, J. Russell, Rt. 2, New London 63459
Florendo, Federico N., Jr., 1734 Market St.
Florendo, Purificacion T., Tower Plaza, Clinic Rd.
Foreman, Phillip B., Box 311
Greene, Harry L., 109 B Virginia
Hall, Stanley G., Sycamore Spring, Rt. 2
Hamlin, Wyeth, Box 311
Hinds, R. David, 3 Paulina Dr.
Jayanandaiah, H. P., 4022 Edgewood
Kruse, Carl R., 706 S. Dickerson, Palmyra 63461
Lanning, Robert J., 7 Cardiff La.
Lichty, Charles A., Shelbina 63468
Mann, James K., 4074 Hillside Dr.
Murphy, Bernard L., 2000 Crescent Dr.
Plowman, Edward M., B & L Bldg.
Rapp, Earl L., Box 311
Roller, Merrill J., 2910 St. Mary's
Steele, James C., Jr., Box 311
Walterscheid, John H., 1209 Broadway
Well, Julius W., Palmyra 63461

MERCER COUNTY
(Grand River Medical Society)

MID-MISSOURI COUNTY MEDICAL SOCIETY
(Phelps-Crawford-Dent-Pulaski-Maries-Laclede Counties)

Andreassen, Dimil F., Rolla 65401
Baumann, Albert R., Steelville 65565
Bealer, Louis A., Lebanon 65536
Butts, James D., Rolla 65401
Carnell, B. M., Camdenton 65020
Carrington, Howard W., Lebanon 65536
Cone, William, General Delivery, Steelville 65565
*Courter, Gary M., Harwood & Chestnut, Lebanon 65536
Drake, Avery A., 4357 N. 106 Ave., Phoenix, Ariz. 85039
Draper, Bernard, 700 W. 11th, Rolla 65401
Elders, Frank A., Jr., Cuba 65453
Feind, Earl E., Rolla 65401
Froelich, R. W., Lebanon 65536
Gapasin, Ernesto, Lebanon 65536
Garrison, T. W., C.P.O. Box 1042, Korea Campus Crusade for Christ, Seoul, Korea
Grannemann, Harry N., 1000 W. 10th St., Rolla 65401
Hammler, Christiana V., St. James 65559
Hayden, M. R., Camdenton Med. Center, Camdenton 65020
Heilbrunn, Ilse, 1203 B Forum Dr., Rolla 65401
Hite, Dennis E., Lebanon 65536
Holley, Donald B., Camdenton 65020
Miller, Clyde S., Waynesville 65583
Mitchell, Roy E., Salem 65560
Myers, James M., Rolla 65401
Pendell, Paul W., 1100 W. 10th, Suite 230, Rolla 65401
Pojanasomboon, Pichat, 1203 Forum Dr., Rolla 65401
Riffel, Gordon W., Bourbon 65441
Russell, Barbara E., Rolla 65401
Smith, Ted P., S&S Acres, Rt. 2, Rolla 65401
Stricker, Emil A., St. James 65559
Tang, T. C., Box 437, Salem Memorial Hospital, Salem 65560
Theobald, Sterling, Box 368, Camdenton 65020
White, Eugene F., 700 W. 11th, Rolla 65401
Young, Robert B., Rolla 65401

MILLER COUNTY MEDICAL SOCIETY

Buehler, Carl T., Jr., Eldon 65026
Shelton, Edward O., Eldon 65026

MINERAL AREA COUNTY MEDICAL SOCIETY
(St. Francois-Iron-Madison-Washington-Reynolds-Bollinger Counties)

Appleberry, Charles H., Rivermines 63668
Arat, Metin, V.A. Hospital, Battle Creek, Mich. 49016
Bentinganan, Victor D., 703 W. Main, Fredericktown 63645
Boonyasai, Boonfu, 321 S. Main, Ironton 63650
Borromeo, Carlos J., 43 St. Joe St., Rivermines 63668
Burcham, Tom R., Jr., Rt. 1, Box 168, Farmington 63640
Cancelada, Juan, Farmington 63640
Carleton, Charles E., Jr., Farmington 63640
Chastain, Charles W., Farmington 63640
Crouch, F. Richard, Farmington 63640
Datta, N. K., Bonne Terre 63628
Dennis, W. Paul, Flat River 63601
Dent, George W., Jr., 301 W. Liberty, Farmington 63640
Dettmer, Robert F., Ironton 63650
Dierker, H. D., 301 W. Liberty Farmington 63640
Farmer, Norma D., Farmington 63640
Ford, William, Farmington 63640
Grossman, Marvin, Fredericktown 63645
Hardy, Stanton L., Desloge 63601
Harland, Robert E., 2500 Torrey Pines Rd., La Jolla, Calif. 92037
Hoctor, Emmett F., Farmington 63640
Hoye, Robert C., 301 W. Liberty, Farmington 63640
Huckstep, Robert A., Rt. 1, Box 3, Farmington 63640
Hunt, John W., Jr., Rt. 4, Box 101, Farmington 63640
Karraker, Alvan G., Medical Arts Clinic, Farmington 63640
Kim, Longius, 43 St. Joe, Rivermines 63668
Mardini, Edward E., Bonne Terre 63628
Menne, Marvin C., Ironton 63650
Mullen, Jack, Bonne Terre 63628
Neukom, George B., Farmington State Hospital #4, Box #6, Farmington 63640
Newcomb, Arthur D., 100 B. W. 10th, Lamar 64759
Nicolay, Bill, Madison Memorial Hospital, Fredericktown 63645
Oliver, George A., Farmington 63640
Pal, Nirmal K., Bonne Terre 63628
Pichardo, Javier A., Farmington 63640
Raksakulthai, V., 703 Main, Fredericktown 63645
Rao, A. R., 703 W. Main, Fredericktown 63645
Sermchief, Chaiyarat, 703 W. Main, Fredericktown 63645
Tan, Sioe Sien, Farmington State Hospital, Farmington 63640
Taylor, Van W., Bonne Terre 63628
Tuttle, Jay F., Farmington State Hospital, Farmington 63640
Vibulakaopun, Pairat, 30 N. Allen, Bonne Terre 63628
Watkins, George L., Jr., 1105 Rancho Rd., La Jolla, Calif. 92037

MISSISSIPPI COUNTY
(SEMO County Medical Society)

MONITEAU COUNTY MEDICAL SOCIETY
(California 65018)

Fulks, Richard B., California
Gallagher, Lionel M., California
Latham, Kenyon S., California

MONROE COUNTY
(Chariton-Macon-Monroe-Randolph County Medical Society)

MONTGOMERY COUNTY MEDICAL SOCIETY

Byland, Samuel J., Wellsville 63384

MORGAN COUNTY MEDICAL SOCIETY
(Versailles 65084)

Gunn, Jack, Versailles
Hall, C. Robert, Versailles

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*Doctor of Osteopathy.

Kauffman, Ruth, Versailles
Lyle, Robert R., Versailles
Washburn, J. Loren, Versailles
Wilcox, Roger, 115 Sunshine, Branson 65616

NEW MADRID COUNTY
(SEMO County Medical Society)

NEWTON COUNTY
(Ozarks Medical Society)

NORTH CENTRAL COUNTIES MEDICAL SOCIETY
(Adair-Schuyler-Knox-Sullivan-Putnam Counties)
(Kirksville 63501)

English, Milton T., Jr., Kirksville
Freeman, Spencer L., Kirksville
Tarvydas, Francis, Edina 63537

NORTHWEST MISSOURI MEDICAL SOCIETY
(Nodaway-Holt-Atchison-Gentry-Worth Counties)

Bare, Edward F., 102 South 6th, Tarkio 64491
Bauman, Henry C., 929 W. 3rd, Maryville 64468
Byland, Benjamin F., Maryville 64468
Carlin, Albert L., Stanberry 64489
Carpenter, Wallace, Rock Port 64482
Dunshee, Robert E., Maryville 64468
Harr, Patrick B., South 71 Hwy, Maryville 64468
Humphrey, James, Mound City 64470
Imes, Elvin D., Maryville 64468
Matteson, Frank B., Grant City 64456
Morgan, Troy O., Jr., Albany 64402
Niedermeyer, Edward L., Tarkio 64491
Wanamaker, John M., Rock Port 64482
Wempe, G. Raymond, Maryville 64468

OREGON COUNTY
(South Central Counties Medical Society)

OSAGE COUNTY
(Unorganized)

OZARK COUNTY
(South Central Counties Medical Society)

OZARKS MEDICAL SOCIETY
(Barry-Lawrence-Stone-Christian-Taney-Newton-McDonald Counties)

Anderson, Paul B., Neosho 64850
Apostol, Andres G., 801 Lincoln St., Monett 65708
Betz, Richard J., Neosho 64850
Betz, Robert F., Neosho 64850
Blankenship, George W., Neosho 64850
Bowman, Melvin C., Neosho 64850
Brown, Frederick B., Aurora 65605
Capetti, Alex P., Crane 65633
Carter, James R., Neosho 64850
Christianson, Charles S., East Texas Chest Hosp., Tyler, Tex 75701
Crain, James W., Branson 65616
Cruz, Sergio G., Jr., 801 Lincoln, Monett 65708
Dabbs, Wilbur D., Neosho 64850
Donley, Robert R., Monett 65708
Esparrago, Francisco R., Jr., Monett 65708
Galinsky, Leon, 164 E. Paseo Chuparosas, GreenValley, Ariz. 65614
Gardner, Joseph W., 8 Walnut Lane, Kimberling City 65686
Gillispie, Roy, Branson 65616
Glass, William J., Jr., Monett 65708
Glover, Kenneth, Mt. Vernon 65712
Graves, Arthur J., Mt. Vernon 65712
Hamilton, William P., Aurora 65605
Hellweg, Charles E., Mt. Vernon 65712
Huntington, Ione, Mt. Vernon 65712
Kelsey, Kenneth L., Aurora 65605
Kenney, Roy E., Neosho 64850
Kerr, Frank T., Monett 65708
Lentz, Harold C., Neosho 64850
Magness, William C., Branson 65616
Mars, Hartley F., Forsyth 65653
Merideth, Mary Jane, Cassville 65625
Montellano, Arturo H., 808 Euclid, Monett 65708
Morrison, T. A., Aurora 65605
Oceeno, Victor G., 808 Euclid, Monett 65708
Olive, George C., Neosho 64850
Parkison, Donald E., Seligman 65745
Regier, Carl M., Skaggs Community Hosp., Branson 65616
Roper, Stanley D., Ozark 65721
Shumate, L. St. Clair, Reeds Spring 65737
Spears, Charles A., 1153 W. Hwy. 76, Branson 65616
Taylor, Leo T., P.O. Box 249, Neosho 64850
Wommack, Fred L., Crane 65633

PEMISCOT COUNTY MEDICAL SOCIETY

Aquino, Philip J., Caruthersville 63830
Bernard, J. W., Caruthersville 63830
Cain, Charles F., Caruthersville 63830
Cook, Oliver W., Caruthersville 63830
Grahle, James, Portageville 63873
Gubin, Alan S., Caruthersville 63830
Kuangparichat, Manoch, 305 N. 18th St., Lexington 64067
McCoy, Warren R., Caruthersville 63830
McKaskle, Clarence W., Caruthersville 63830
Painter, Andrew E., Portageville 63873
Painter, Lattie B., Jr., Portageville 63873
Shirey, Arnold G., Hayti 63851

PERRY-STE. GENEVIEVE COUNTIES MEDICAL SOCIETY

Carron, Oscar A., Perryville 63775
DeGenova, Gerard H., Ste. Genevieve 63670
Eugenio, Romeo R., Perry Plaza Medical Center, Perryville 63775
Fairchild, James F., Perryville 63775
Feltz, Lawrence W., Perryville 63775
Fischer, Theodore, Altenburg 63732
Key, Martin L., Center Dr. & Hospital La., Ste. Genevieve 63670
Limpiphiphatn, Dhajphone, Perry Plaza Med. Center, Perryville 63775
Limpiphiphatn, Ester, Perry Plaza Med. Center, Perryville 63775
Lutkewitte, Joseph F., Ste. Genevieve 63670
McDermott, Alfred E., Perryville 63775
Pontillas, Job B., Perryville 63775
Utterman, William F., Lake Forest Estates, Ste. Genevieve 63670

PETTIS COUNTY MEDICAL SOCIETY
(Sedalia 65301)

Block, J. E., Rt. 2, Box 53B
Boger, James W., 500 W. 16th St.
Braverman, Elliot M., 1501 S. Grand Ave.
Brazos, John C., Smithton 65350
Campbell, Albert J., Jr., 625 E. 13th
Cole, William R., Rt. #1, Smithton 65350
Daum, Harold F., Bothwell Memorial Hosp.
Edmonds, Robert W., 1718 S. Ingram
Edwards, David R., 700 S. Limit
Eldenburg, Donald, 700 S. Limit
Erickson, H. John, 1501 S. Grand
Farkas, James R., Bothwell Memorial Hospital
Fisher, Stanley D., 500 W. 16th
Glass, Robert L., 403 W. Broadway, Columbia 65201
Hopkins, Thomas J., 700 S. Limit
Hopkins, T. Spencer, 1718 S. Ingram
Lamy, John E., 400½ Dal-Whi-Mo
Lowe, Alvin L., 621 W. 16th St.
Maddox, Albert R., 116 W. Main
Owens, John H., Bothwell Memorial Hosp.
Proctor, Donald C., 700 S. Limit
Roberts, Paul A., Sweet Springs 65351
Showe, Robert J., 1718 S. Ingram
Stauffacher, C. Gordon, 700 S. Limit
Stewart, Robert H., 201 Driftwood Dr.
Stockwood, Robert C., 1718 S. Ingram
Van Dyke, Elmer H., 1718 S. Ingram
Walter, Archie L., 500 W. 16th St.
Worley, Charles A., Sweet Springs 65351

PHELPS COUNTY
(Mid-Missouri County Medical Society)

PIKE COUNTY MEDICAL SOCIETY

Duensing, George F., 211 S. 3rd, Louisiana 63353
Jackson, Edward K., 215 S. Third, Clarksville 63336
Lewellen, Charles H., Louisiana 63353
Martin, W. Joe, Louisiana 63353
Middleton, John W., Louisiana 63353
Miles, Glenn E., Louisiana 63353
Nickels, Mathew L., 420 Forest Hills Dr., Louisiana 63353
Stuerman, Lawrence G., 211 S. 3rd., Louisiana 63353
Wilcoxen, William B., Bowling Green 63334

PLATTE COUNTY MEDICAL SOCIETY

Allen, S. Lloyd, 3809 N.W. 62 Terr., Kansas City 64151
Kimball, Ireland W., 5621 Valley Rd., Kansas City 64151
Thurman, Hill C., Parkville 64152
Vescovo, Paul C., 4106 Vivion Rd., Kansas City 64119
Wolfram, Philip H., 620 Commercial, Smithville 64089

POLK COUNTY
(Dallas-Hickory-Polk-Dade County Medical Society)

PULASKI COUNTY
(Mid-Missouri County Medical Society)

PUTNAM COUNTY
(North Central Counties Medical Society)

RALLS COUNTY
(Marion-Ralls-Shelby County Medical Society)

RANDOLPH COUNTY
(Chariton-Macon-Monroe-Randolph County Medical Society)

RAY COUNTY
(Lafayette-Ray County Medical Society)

REYNOLDS COUNTY
(Mineral Area County Medical Society)

RIPLEY COUNTY
(Butler-Wayne-Ripley County Medical Society)

ST. CHARLES-LINCOLN COUNTY MEDICAL SOCIETY
(St. Charles 63301)

Alisuag, Andres, Jr., 2850 W. Clay
Altman, Marvin P., 2850 W. Clay
Alul, Michael, 1650 Boonslick
Baird, Keim L., 2850 W. Clay St.
Cabrera, Tomas V., 79 Cottleville, St. Peters 63376
Canty, Eugene J., 114 N. Main
Carpenter, James L., 2 Westbury Square
Clever, Henry W., Jr., 1301 Boonslick Rd.
Commerford, John F., 1301 Boonslick Rd.
Connelly, Michael W., #18 Huntleigh Downs, Frontenac 63131
Cova, Reno R., Jr., 11115 New Halls Ferry, Florissant 63031
Creech, Joseph C., Troy 63379
Crider, Russell J., 222 S. 2nd St.
Curry, Michael J., 2850 W. Clay
Damron, Edward O., Elsberry 63343
Del Pizzo, Ferdinand, Jr., 1301 Boonslick Rd.
Desai, Ravindra, 2850 W. Clay
Difilippo, Emil A., 14824 Wood Ford Way, Bridgeton, 63044
Duling, Gerald J., 2850 W. Clay St.
Dumonceaux, Leonard J., 1360 S. 5th
DuMontier, R. J., O'Fallon 63366
Duncan, David, 2850 W. Clay
Fajatin, Romulo J., #2 Westbury
Felder, James P., 515 Jefferson
Fleming, Robert J., 120 First Capitol Dr.
Floerchinger, James S., St. Charles Clinic
Goldkamp, John D., 2850 W. Clay St.
Gore, Glenn L., 1650 Boonslick
Hammes, Roman E., 2850 W. Clay St.
Hetlage, Louis P., Troy 63379
Kamada, Tsutomu, 115 W. Pitman, O'Fallon 63366
Keefe, David M., 2850 W. Clay
Keller, Robert, 704 W. Pearce Blvd., Wentzville 63385
Kingsbury, Robert J., 222 South 2nd
Kister, George E., 302 S. 2nd St.
Linsenmeyer, Charles M., 117 First Capitol Dr.
McQueen, Samuel, 11636 Administration Dr., St. Louis 63141
Muenster, Vincent P., 2850 W. Clay St.
Muhm, Harvard Yale, 1301 Boonslick
Neubeiser, Ben L., 2nd & Clay Sts.
Obando, Francisco J., Troy 63379
Olson, Richard O., Jr., 2850 W. Clay
Ordoukhanian, Tatool, 1301 Boonslick
Perez, Romulo G., 415 E. Cherry, Troy 63379
Perna, Vincent P., 11636 Administration Dr., Creve Coeur 63141
Poggemeier, William H., Jr., 304 S. 2nd St.
Rahman, Mohammad H., 2850 W. Clay
Reisa, Ronald C., 2850 W. Clay
Rice, Ronald B., 1301 Boonslick
Roach, Edward A., 2850 W. Clay St.
Roter, Alexander M., #2 Westbury Dr.
Rother, Paul H., 1301 Boonslick Rd.
Roxas, Generoso P., #3 Westbury
Schneider, Thomas A., 2850 W. Clay St.
Schuetz, Alfred, 904 Indian Hills
Smoller, Martin B., 2850 W. Clay St.
Soucy, John C., 2850 W. Clay
Swarez, Pedro L., 1360 South 5th
Taglia, Santo W., 2850 Clay
Tassi, Albert A., 601 Indian Hills
Tejero, Jonas S., 1650 Boonslick
Thiele, O. K., #2 Westbury

° Doctor of Osteopathy.

Towers, Orville W., 1301 Boonslick Rd.
Vafi, Houshang, 1360 S. 5th
Vart, Gary R., 1650 Boonslick
Vighi, James R., 2850 W. Clay
Westerfeld, Roy A., 1301 Boonslick Rd.
Wipfler, Earl J., Jr., 405 Duckett
Yaeger, Gerald A., 2444 W. Clay St.

ST. CLAIR COUNTY
(West Central Missouri Medical Society)

ST. FRANCOIS COUNTY
(Mineral Area County Medical Society)

STE. GENEVIEVE COUNTY
(Perry-Ste. Genevieve Counties Medical Society)

ST. LOUIS MEDICAL SOCIETY
(St. Louis)

Abel, Charles C., 4511 Forest Park Blvd. 63108
Abel, Oliver, III, 4511 Forest Park Blvd. 63108
Abelardo, Miguel L., 300 S. Grand 63139
Abell, Walter E., 2253 S. 39th St. 63110
Abinoja, Conrado B., 4909 Lindenwood 63109
Abrams, Morris, #319, 4625 Lindell Blvd. 63108
Abramson, Charles L., 141 N. Meramec 63105
Acker, Harry L., 950 Francis Pl. 63105
Ackerman, Lauren V., 1353 Greentree Ln. 63122
Adeyemi-Doro, Henry, 2601 N. Whittier 63113
Adler, Benard C., 4511 Forest Park Blvd. 63108
Afuwape, Emmanuel A., 2601 N. Whittier 63113
Agasino, Armela R., 2244 Union Rd. 63125
Agasino, Gaudencio L., 20 Hughes Ford Rd., Sullivan 63080
Agress, Harry, 8631 Delmar 63124
Aguinaldo, Jaime A., 9313 Manchester 63119
Ahadi, Abd Ul Ahad, 13029 Ambois Dr. 63141
Ahern, Archibald M., 3915 Watson Rd. 63109
Ahlering, George H., #560, 621 S. New Ballas Rd. 63141
Ahmad, Bashir, 7933 Elton 63123
Ahuja, A. L., 5400 Arsenal 63139
Aitken, Louis F., 4989 Barnes Hosp. Plaza 63110
Aker, Umit, 911 S. Brentwood 63105
Akyol, Salim, #4 Highfield Lane 63131
Alegre, Jorge M., 114 N. Taylor 63108
Aleksander, Bernardo, 1420 Grattan 63104
Alexander, France, 18 S. Kingshighway 63108
Alexander, Frazier D., 4969 Enright Ave., 63108
Allen, Henry C., 2821 N. Ballas 63131
Allen, Hollis N., 2821 N. Ballas Rd. 63131
Allen, Melvin A., 3555 Sunset Office Dr. 63127
Allen, Willard M., University of Maryland, Baltimore, Md. 21201
Allen, William E., Jr., 720 N. Sarah 63108
Almiron, Osias A., 120 Progress Pkwy., Maryland Heights 63043
Alonso, Jose Mario V., Jr., 10110 Hilltop Dr. 63128
Alonso, William A., 4989 Barnes Hosp. 63110
Alonso-Yague, P., 330 Northland Medical Bldg. 63136
Altheide, J. Paul, 4605 Lindell 63108
Alvarez, Luis L., 1606 Grattan 63104
Alvis, Bennett Y., 211 N. Meramec 63105
Alvis, Edmund B., 211 N. Meramec 63105
Amado-Ledo, David E., 300 S. Grand Blvd. 63103
Amin, Navinkumar, 607 N. Grand Blvd. 63103
Amjad, Mohammed T., 1211 Blairshire Dr. Manchester 63011
Analkat, H. N., 2639 Miami 63118
Anderson, Charles B., 14 Frederick 63122
Anderson, John M., 100 N. Euclid 63108
Angelillo, John C., 4 Waterways Ct., Florissant 63033
Anglo, Luis B., 3912 Ritz Center 63125
Ansari, Ansar H., 530 W. Adams, Pittsfield, Ill. 62363
Anstey, George, 10449 St. Charles Rock Rd., St. Ann 63074
Anthony, Elwyn J., 369 N. Taylor Ave. 63108
Archer, Carol R., 510 S. Kingshighway 63110
Arenberg, Irving K., 517 S. Euclid 63110
Arias, Fernando, Barnes Hospital Plaza 63110
Arneson, Axel N., 4511 Forest Park 63108
Arney, William G., 16 Hampton Village Plaza 63109
Arnold, Kenneth J., 4989 Barnes Hospital Plaza 63110
Arnot, John P., 35 N. Central Ave. 63105
Arribas, Neva P., 4989 Barnes Hospital Plaza 63110
Auer, Arthur I., 667 Langton 63105
Auer, Edward T., #9 Clayton Terr. 63131
Aufderheide, G. R., 216 Northland Medical Bldg., 63136
Auguste, Jean Meledain, 4400 Lindell Blvd. 63108
Augustin, Cesar, 17 Friese Dr. 63132
Avioli, Louis V., P.O. Box 14109 63178
Aykent, Yavuz, 911 S. Brentwood Blvd. 63105
Aylward, Howard J., 6651 Chippewa 63109
Azuma, Nobutaka, 3901 Tholozan 63116
Azzouni, Joseph N., P.O. Box 201, High Ridge 63049
Babka, Joseph J., 3845 Federer Pl. 63116
Backer, Matthias H., Jr., 10345 Watson Rd. 63127
Badger, Virginia M., 113 Stoneyside Lane 63132
Bailey, Drennan, 6356 Clayton Rd. 63117
Baldwin, Richard, Jr., 50 Overhill 63124
Ballal, H. S., 6150 Oakland 63139
Ballinger, Walter F., II, 4960 Audubon Ave. 63110
Bandle, Donald F., 3801 January Ave. 63139
Banet, Samuel R., 83 Pebblebrook Lane 63141
Banton, M. Roman, 13634 Peacock Farm Rd. 63131
Banton, Thomas J., 114 Northland Medical Bldg. 63136
Banton, William C., 601 S. Brentwood 63105
Bardsley, John L., 621 S. New Ballas Rd., 63141
Barner, Hendrick, 1325 S. Grand Blvd. 63104
Barrett, Scott R., 5505 Delmar 63112
Bartlett, Robert W., 6459 Wydown Blvd. 63105
Bartnick, Mitchel L., RR #2, Box 38, De Soto 63020
Baue, Arthur E., P.O. Box 14109 63178
Bauer, Eugene A., Barnes Hosp. Plaza 63110
Bauer, John D., Northland Medical Bldg. 63136
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Mrs. Robert C. Stockwood (Jackie)
Rt. #3 Walnut Hills, Sedalia 65301

Mrs. A. J. Campbell (Janet)
1500 West 16th, Sedalia 65301

MISSOURI STATE CONVENTION—April 1-4, 1976
Crown Center Hotel, Kansas City

Co-Chairmen
Mrs. W. Jack Stelmach (Pat)
4303 W. 93rd Terr., Shawnee Mission, Kan. 66208
Mrs. R. Stacy Long (Frances)
3343 Blue Ridge Blvd., Independence 64052

ORGANIZED COUNTIES AND PRESIDENTS

(Counties Listed Alphabetically)

Boone
Mrs. Carl Almond (Nancy)
213 West Blvd. South, Columbia 65201
Buchanan
Mrs. Edward Stevens (Anita)
2923 Joslin La., St. Joseph 64506
Butler-Ripley-Wayne
Mrs. Fred Caldwell (Patty)
2008 King Rd., Poplar Bluff 63901
Cape Girardeau
Mrs. Ray Ritter (Ann)
2408 Terry Hill, Cape Girardeau 63701
Callaway
Mrs. Vernon Jackson (Arlene)
3 Staff Circle, Fulton 65252
Clay
Mrs. Jerry Kirkland (Verda)
6604 N.W. Overland Dr., Kansas City 64151
Cole
Mrs. James Gordon (Jean)
600 Boonville Rd., Jefferson City 65101
Cooper
Mrs. E. T. Humphreys (Annie)
1123 Third St., Boonville 65233
Dunklin
Mrs. John Legan (Marilyn)
617 Butler Dr., Kennett 63857
Franklin-Gasconade-Warren
Mrs. Donald L. Baker (Evelyn)
900 Clearview Dr., Union 63084
Grand River
Mrs. Thomas N. Cofer (Bobbe)
503 Elmdale Rd., Chillicothe 64601
Greene
Mrs. William Penninger (Marjorie)
2246 Claiborne, Springfield 65804
Jackson
Mrs. Calvin E. Englemann (Anneliese)
2000 West 68th, Shawnee Mission, Kan. 66208
Jasper
Mrs. David Straub (Myra)
811 N. Byers, Joplin 64801
Jefferson
Mrs. Andres S. Bonifacio (Nanette)
Rt. #4, Festus 63208
Johnson
Mrs. Jerry Raglund (Mary)
Rt. #4, Warrensburg 64093
Lafayette-Ray
Mrs. Hugh Brady (Macy)
Box N, Concordia 64020
Miller-Morgan-Moniteau
Mrs. T. Carl Buehler, Jr., (Jimmy)
608 E. Newton, Eldon 65206
Mineral Area
Mrs. C. W. Chastain (Caroline)
301 W. Liberty, Farmington 63640
Pettis
Mrs. Donald Eldenburg (Charlotte)
Rt. #2, Sedalia 65301
St. Charles-Lincoln
Mrs. H. Yale Muhm (Paula)
548 Riverview La., St. Charles 63301
St. Louis City
Mrs. Clement Sullivan (Frances)
7740 Mohawk Dr., St. Louis 63105
St. Louis County
Mrs. Rudy Ruhling (Dolores)
6 Webster Knolls, Webster Groves 63119
Saline
Mrs. Marvin Roehrs (Bonnie)
756 E. Eastwood, Marshall 65340
South Central
Mrs. C. Franklin Smith (Peggy)
Hickory Hills Estates, Willow Springs 65793

AUXILIARIES AND COUNTY MEDICAL SOCIETIES LISTED BY DISTRICTS

FIRST DISTRICT: Andrew,* BUCHANAN, CLAY, Clinton,* GRAND RIVER (Caldwell, Carroll, Daviess, DeKalb, Grundy, Harrison, Linn, Livingston, Mercer), Northwest Missouri (Nodaway, Holt, Atchison, Gentry, Worth),* Platte.*

SECOND DISTRICT: Chariton-Macon-Monroe-Randolph,* Clark-Lewis-Scotland,* Marion-Ralls-Shelby,* North Central (Adair, Knox, Putnam, Schuyler, Sullivan).*

THIRD DISTRICT: ST. LOUIS CITY.

FOURTH DISTRICT: FRANKLIN-GASCONADE-WARREN, JEFFERSON, Lincoln-St. Charles, ST. LOUIS COUNTY.

FIFTH DISTRICT: AUDRAIN, BOONE, CALLAWAY, Camden,** COLE, COOPER, Howard,* MILLER-MORGAN-MONITEAU, Montgomery,* Osage.**

SIXTH DISTRICT: Benton,* Henry,* JOHNSON, LAFAYETTE-RAY, PETTIS, SALINE, WEST CENTRAL (Bates, Cass, Cedar, St. Clair, Vernon).

SEVENTH DISTRICT: JACKSON COUNTY.

EIGHTH DISTRICT: Barton,* Dallas-Hickory-Polk-Dade,* GREENE, JASPER, Ozarks** (Barry, Christian, Lawrence, McDonald, Newton, Stone, Taney),* Webster.*

NINTH DISTRICT: Shannon,* Mid-Missouri (Crawford, Dent, Laclede, Maries, Phelps, Pulaski),* SOUTH CENTRAL (Douglas, Howell, Oregon, Ozark, Texas, Wright).

TENTH DISTRICT: Bollinger,** BUTLER-RIPLEY-WAYNE-CARTER, CAPE GIRARDEEAU, DUNKLIN, MINERAL AREA (Iron, Madison, Reynolds, St. Francois, Washington), Pemiscot,* Perry-Ste. Genevieve, SEMO (Mississippi, New Madrid, Scott, Stoddard).*

CAPITALIZED COUNTIES—Organized Auxiliary.
* No organized Auxiliary.
** No Medical Society.

STATE PAST PRESIDENTS—1924-1975

Mrs. George H. Hoxie* (Jackson)**	1924-25
Mrs. M. P. Overholzer* (West Central)	1925-26
Mrs. Arthur B. McGlothlan (Buchanan)** 821 N. 24th, St. Joseph 64506	1926-27
Mrs. W. M. Bickford* (Saline)	1927-28
Mrs. Willard Bartlett, Sr. (St. Louis City) 53 Westmoreland Pl., St. Louis 63108	1928-29
Mrs. M. P. Ravenal* (Boone)	1929-30
Mrs. A. W. McAlester* (Jackson)	1930-31
Mrs. U. J. Busiek (Greene) 1635 E. Walnut, Springfield 65802	1931-32
Mrs. David S. Long (West Central) M. 40, Lake Lotawana, Lee's Summit 64063	1932-33
Mrs. Hudson Talbot (St. Louis City) St. Matthew Manor, 227 Brown's Lane, Louisville, Ky. 40207	1933-34
Mrs. W. H. Goodson* (Clay)	1934-35
Mrs. M. Pinson Neal* (Boone)	1935-36
Mrs. Walter C. Kirchner* (St. Louis City)	1936-37
Mrs. Charles H. Werner* (Buchanan)	1937-38
Mrs. Herbert L. Mantz (Jackson) 1209 Romany Rd., Kansas City 64113	1938-39
Mrs. Paul F. Cole (Greene) 1819 Main, Quincy, Ill. 62301	1939-40
Mrs. S. P. Howard* (Cole)	1940-41
Mrs. J. J. Drace (Cape Girardeau) 903 Bellevue, Cape Girardeau 63701	1941-42
Mrs. Frank L. Davis* (St. Louis City)	1942-43
Mrs. Robert C. Haynes (Saline) 754 Eastwood, Marshall 65340	1943-44
Mrs. J. B. McCubbin* (Callaway)	1944-45
Mrs. Harry M. Gilkey* (Jackson)	1945-46
Mrs. W. E. Koppenbrink, Sr. (Lafayette-Ray) 1303 Main, Higginsville 64037	1946-47
Mrs. W. L. Allee* (Miller-Morgan-Moniteau)	1947-48
Mrs. August A. Werner* (St. Louis City)	1948-49
Mrs. John J. O'Connell (St. Louis County) 1937 O'Connell Ave., Overland 63114	1949-50
Mrs. Gretchen Van Del McClean (Jackson) 3510 Front St., San Diego, Calif. 92103	1950-51
Mrs. W. Carey Cheek (Greene) 1535 E. Meadowmere, Springfield 65804	1951-52
Mrs. Richard A. Sutter (St. Louis County)** 7215 Greenway Dr., University City 63130	1952-53
Mrs. C. Alex McBurney (Saline) 927 Hurt, Slater 65349	1953-54
Mrs. Wilfred E. Martin (Lafayette-Ray) 403 E. 2nd, Odessa 64076	1954-55
Mrs. Frank B. Leitz (Jackson) 308 W. 116th, Kansas City 64114	1955-56
Mrs. Charles T. Shepherd (St. Louis County) 10 Covington Meadows, St. Louis 63131	1956-57
Mrs. Armand D. Fries (St. Louis City) 11 W. Geyer Lane, St. Louis 63131	1957-58
Mrs. Henry C. Bauman (Nodaway-Holt-Atchison-Gentry-Worth) 929 W. 3rd, Maryville 64468	1958-59
Mrs. Stanley S. Peterson (Greene) 721 E. Stanford, Springfield 65804	1959-60
Mrs. Jordan Kelling (Lafayette-Ray) P. O. Box 171, Waverly 64096	1960-61
Mrs. Frederick E. Wade (Jackson) 413 W. 62nd, Kansas City 64113	1961-62
Mrs. J. Martyn Schattyn (St. Louis County) 9 Huntleigh Downs, Frontenac, St. Louis 63131	1962-63
Mrs. Lawrence S. Crispell (Jasper County) 911 Kensington, Joplin 64801	1963-64
Mrs. Delevan Calkins* (St. Louis City)	1964-
Mrs. Ralph Woods Bohnsack (Grand River) 635 Skyline Dr., Brookfield 64628	1964-66
Mrs. Wallace R. Stacey (Jackson) 3407 Shady Bend Dr., Independence 64052	1966-67
Mrs. John M. Williams (Clay) 616 Ridgeway Dr., Liberty 64068	1967-68
Mrs. E. F. Butler (Buchanan) 3110 Douglas, St. Joseph 64506	1968-69
Mrs. James A. Reid (Saline) 102 E. Rea, Marshall 65340	1969-70
Mrs. William M. Walker (Greene) 845 Southern Hills Blvd., Springfield 65804	1970-71
Mrs. Frank J. Valach (St. Louis County) 4 Nassau Circle, Creve Coeur 63141	1971-72
Mrs. Keith D. Jones (Johnson) 711 S. Holden, Warrensburg 64093	1972-73
Mrs. Charles R. William (Buchanan) 2105 Lovers Lane, St. Joseph 64505	1973-74
Mrs. George J. Lytton (Jackson) 617 W. 49th, Kansas City 64112	1974-75

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* Deceased.

** National President.

For Your Convenience—

New Members . . . Address Changes . . . Notes

This page is provided for your convenience in recording names and addresses of new members of your county auxiliary, address changes of members you know and other notations you may wish to make.

Roster of Woman's Auxiliary Members by Society

BOONE COUNTY
(Columbia 65201)

Allen, Mrs. Joseph, 5813 St. Charles Rd.
Allen, Mrs. Robert, 4900 St. Charles Rd.
Allen, Mrs. William, 508 W. Briarwood La.
Almond, Mrs. Carl, 213 W. Blvd. South
Arnold, Mrs. Richard C., 814 Yale
Asel, Mrs. Norman, 1112 S. Glenwood
Baker, Mrs. James M., Rt. 4
Baker, Mrs. Sherwood A., 2620 Walther Ct.
Barbee, Mrs. Charles W., 3816 Cedar La.
Black, Mrs. Samuel, 300 S. Glenwood
Blackwell, Mrs. Charles, 3109 W. Rollins
Bourgeois, Mrs. Curtis, Rt. 1, Rocheport 65279
Burns, Mrs. Thomas W., 310 E. Brandon Rd.
Bynum, Mrs. William R., 2606 Luan Ct.
Carnahan, Mrs. Charles E., 3801 Cedar La.
Chalkley, Mrs. Judson, 614 W. Stewart Rd.
Cheek, Mrs. Charles W., 2700 Malibu Ct.
Cochran, Mrs. Donald, 112 Sappington
Colwill, Mrs. Jack, Countryshire, Rt. 5
Cooper, Mrs. Maurice, 1000 Wayne Rd.
Cope, Mrs. James, Rt. 1, Rocheport 65279
Carnell, Mrs. Thomas F. B., 2617 Walther Ct.
Denninghoff, Mrs. James C., 1906 Vassar
Dexheimer, Mrs. Frank, 1004 Hulen Dr.
Dexter, Mrs. James D., 510 Fairview Rd.
Eggers, Mrs. G. William, 1005 Cowan Dr.
Ferneau, Mrs. James, 1040 Queen Ann Dr.
Foote, Mrs. Jerry E., Rt. 4
Frueh, Mrs. Bartley, 108 Park Hill Ave.
Fuchs, Mrs. George, Jr., 1026 Hickory Hill Dr.
Galeota, Mrs. William, 1719 Ridgemont
Gammel, Mrs. George, 1602 Stony Brook
Garrett, Mrs. Glen, 102 E. Brandon Rd.
Garrotto, Mrs. Lewis, 814 Hulen Dr.
Griffin, Mrs. William T., 822 Greenwood Ct.
Hall, Mrs. David G., 1031 Bourn Ave.
Hardwicke, Mrs. Henry, Ashland 65010
Harris, Mrs. Hugh S., Jr., 801 Cowan Dr.
Harris, Mrs. Robert J., 2505 E. Broadway
Hart, Mrs. William, 109 Sappington Dr.
Henry, Mrs. Lawrence D., 1909 Princeton
Hubbell, Mrs. Ira G., 302 McNab Dr.
Hueser, Mrs. James, 604 W. Broadway
Ide, Mrs. Carl, 600 Laurel Dr.
Jackson, Mrs. Robert L., 1103 W. Stewart Rd.
Johnson, Mrs. Richard E., 129 Lindell Dr.
Kaplan, Mrs. Michael F., 1409 Overhill Rd.
Kays, Mrs. Kenneth M., 1033 Bourn
Keown, Mrs. Kenneth, 402 Westmount
Kerr, Mrs. Earl S., 1308 Fieldcrest
La Chance, Mrs. Leopold, 324 S. Collier, Centralia 65240
Ladenson, Mrs. Roland, 704 Westmount
Landhuis, Mrs. Leo R., Rt. 3
Leech, Mrs. Charles A., 815 W. Stewart Rd.
Leeper, Mrs. Sidlee W., 606 W. Stewart Rd.
Lehr, Mrs. James, 2104 Iris Dr.
Litwiller, Mrs. Raymond W., 1312 W. Broadway
Lodwick, Mrs. Gwilyn S., 911 LaGrange Rd.
Logue, Mrs. John, 912 Crestland
Lohmar, Mrs. Roland E., Rt. 5, Box 335
Marienfeld, Mrs. Carl, Rt. 1, Ashland 65101
Mayer, Mrs. William D., 1 Ridgeley Rd.
McCord, Mrs. E. Scott, 410 Spring Valley Rd.
McElroy, Mrs. Glenn, 3909 W. Broadway
Miller, Mrs. LeRoy, 32 Bingham Rd.
Mitchell, Mrs. Frank, 2208 Danforth Ct.
Mitchell, Mrs. Lynn D., 200 Defoe Dr.
Moogan, Mrs. Philip E., 2019 Crestridge
Mosby, Mrs. Larry D., 107 E. Brandon
Orth, Mrs. D. Gerald, 2404 Beachview Dr.
Overholser, Mrs. Milton, 110 E. Brandon Rd.
Payne, Mrs. David, 1901 Ridgemont
Payne, Mrs. John, Route 5, Fulton 65251
Perez-Mesa, Mrs. Carlos, 609 Stewart Rd.
Peterson, Mrs. Charles, Rt. 4
Pfefer, Mrs. Leland U., 2409 Buff Blvd.
Pickard, Mrs. Clarence, 1213 Parkridge Dr.
Pingleton, Mrs. William, 113 Tracy Dr.
Politte, Mrs. Lenard, Rt. 1, Cedar Grove
Prendergast, Mrs. T. J., 600 Woodridge
Rall, Mrs. Kenneth, 1121 Danforth Dr.
Ridenhour, Mrs. C. E. Gene, Rt. 1, Cedar Gove
Rodgers, Mrs. Elrie, 202 S. Glenwood
Rogers, Mrs. Wallace, Ashland 65010
Ross, Mrs. Gilbert, Rt. 1
Russell, Mrs. Garth, 1210 W. Broadway
Scheuber, Mrs. Charles, 505 W. Boulevard S.
Smith, Mrs. J. Ned, Jr., 701 W. Boulevard S.
Smith, Mrs. Joe R., 222 East Parkway
Spratt, Mrs. John, Jr., 105 S. Glenwood
Spurgeon, Mrs. Milo J., 404 Edgewood Ave.
Stephenson, Mrs. Hugh E., 5 Danforth Circle
Stewart, Mrs. W. B., 1401 Ridgemont
Stoy, Mrs. Robert, 811 Canterbury Dr.
Stradford, Mrs. H. Todd, 82 El Chaparral
Struessel, Mrs. Kenneth, 3717 Woodridge Ct.
Thomas, Mrs. Robert M., 2219 Danforth Ct.
Van Dervoort, Mrs. Robert L., 3818 Cedar La.
Waggoner, Mrs. Charles, 712 Hilltop Dr.
Washington, Mrs. Edward L., 204 W. Stewart Rd.
Watson, Mrs. Trevor F., 2319 Bluff Blvd.
White, Mrs. Joseph, 222 W. Brandon Rd.
Wilson, Mrs. George P., 918 Westwinds Dr.
Wilson, Mrs. John, 1117 Woodhill Rd.
Wilson, Mrs. Vernon E., 300 E. Briarwood La.
Woodruff, Mrs. Calvin, 910 Wayne Rd.

BUCHANAN COUNTY
(St. Joseph)

Acuff, Mrs. Robert P., 3015 Miller Rd. 64506
Andres, Mrs. Edward, 2323 NW Ext. Blvd. 64506
Baker, Mrs. W. C., Savannah 64485
Bartulica, Mrs. Nicholas, Box 265, Farleigh Station 64506
Beck, Mrs. Paul, 3216 Coronado 64505
Beheler, Mrs. Edward M., 4609 Stonecrest Terr. 64506
Benson, Mrs. Scott C., 4515 Stonecrest Terr. 64506
Berney, Mrs. Francis J., 1225 N. 10th 64501
Bryant, Mrs. Sydney L., 1805 N. 33rd 64506
Butler, Mrs. E. F., 3110 Douglas 64506
Callman, Mrs. George, P. O. Box 655, Farleigh Station 64506
Carle, Mrs. Rachel, 2707 N. 26th 64506
Carpenter, Mrs. G. Tyson, 2612 Indian Trail 64506
Chiarottino, Mrs. Joseph F., 419 N. 21st 64501
Christ, Mrs. Martin H., 414 Benton Dr. 64504
Cox, Mrs. John P., 4208 Miller Rd. 64505
Craig, Mrs. Owen W. D., 2408 Colony Sq. E 64506
Craig, Mrs. Richard O., 4106 Miller Rd. 64505
Du Mont, Mrs. Clement, 1905 Francis 64501
Durham, Mrs. S. L., Dearborn 64439
Dyer, Mrs. Gary A., 802 N. 25th 64506
Eller, Mrs. Gordon W., 75 Eastwood Dr. 64506
Fisher, Mrs. Joseph L., 2309 Ashland 64506
Forgrave, Mrs. John R., 2611 Cornell 64506
Forgrave, Mrs. Leon Paul, Hundley Dr. 64506
Forman, Mrs. George W., 2412 Ashland 64506
Garrison, Mrs. David L., 5101 E. Crest Ct. 64506
Grimes, Mrs. Manning E., 815 N. Noyes Blvd. 64506
Gunter, Mrs. Joe S., 5710 Karrasch 64505
Hayes, Mrs. Paul W., 610 N. Noyes Blvd. 64506
Herman, Mrs. Allen I., 1909 N. 32nd 64506
Howden, Mrs. T. L., 2723 Francis 64501
Ide, Mrs. Lucien W., 1416 N. 25th 64506
Kelly, Mrs. Gilbert, Savannah 64485
Kieber, Mrs. R. W., 1915 N. 33rd 64506
Knepper, Mrs. Paul, 2002 Ashland 64506
Kulowski, Mrs. Jacob, 5106 Stonecrest Terr. 64506
Lee, Mrs. Carleton H., 2716 Douglas 64506
Luckinbill, Mrs. Paul, Plattsburg 64477
Luechtefeld, Mrs. Frank R., 4915 Stonecrest 64506
Maginn, Mrs. R. L., 12 Wishbone Rd. 64506
Marston, Mrs. F. James, 2114 Lovers La. 64505
Martin, Mrs. John, 9 Lindenwood La. 64505
McDaniel, Mrs. John R., 1808 N. 29th 64506
McDonald, Mrs. Wallace, 3309 Karnes Rd. 64506
McDonald, Mrs. Wilbur P., 6 Country Club Rd. 64505
Meriwether, Mrs. Don R., 2400 Lucille Ave. 64506
Moen, Mrs. Berwyn H., 2214 Carper Dr. 64506
Morse, Mrs. John Philip, 2212 Lovers La. 64505
Mothershead, Mrs. John L., 2630 Farleigh Terr. 64506
Mullican, Mrs. Charles N., 2103 Lovers La. 64505
Ness, Mrs. Carl K., 8 Lindenwood La. 64505
O'Brien, Mrs. Liam, State Hospital, Box 263 64502
O'Connor, Mrs. William B., 2316 N. 22nd 64505
Ozenberger, Mrs. Larry, 302 Birch Ave., Plattsburg 64477
Partamian, Mrs. Krikor O., 3405 Colony Square W. 64506
Peterson, Mrs. Harold E., 2903 Frederick 64506
Pfeffer, Mrs. Robert, 1915 N. 29th 64506
Paulson, Mrs. Gordon, 820 Ashland Ave. 64506
Pifer, Mrs. Lawrence H., 2120 Manchester Rd. 64505
Potter, Mrs. Caryl, Jr., 1 Pine Rd. 64505
Potter, Mrs. Thompson E., 2106 Lovers La. 64505
Prokop, Mrs. Joseph R., 29 Stonecrest, 64506
Redmond, Mrs. William, 3102 Jule 64501
Riddell, Mrs. Richard V., 2610 Indian Trail Dr. 64506
Rogers, Mrs. John T., 2502 Ashland 64506
Rosenthal, Mrs. Irwin, 5007 Stonecrest Terr. 64506
Rost, Mrs. William B., 2221 Northwest Ext. 64506
Saferstein, Mrs. T. H., 2903 Sherman 64504
Senne, Mrs. Herbert C., 1308 S. Noyes 64507
Senor, Mrs. Earl, 2920 Renick 64507
Sheppard, Mrs. Julius K., 1103 N. 49th Terr. 64506
Shevlin, Mrs. Charles F., 840 N. 25th 64506
Silliman, Mrs. York E., 2631 Felix 64501
Sklenar, Mrs. Donald E., 3910 N. 71 Highway 64506
Smith, Mrs. Clifton, 2821 Ashland 64506
Stallard, Mrs. Donald J., 1417 N. 25th 64506
Stevens, Mrs. Edward, 2923 Joslin La. 64506
Stuber, Mrs. Robert R., 2614 Buehler 64506
Thomas, Mrs. Forrest, 1301 N. 25th 64506
Thompson, Mrs. F. Gregg, III, 2714 Ashland 64506
Villahermosa, Mrs. Juanito, 511 Crestview Dr., Savannah 64485
Wadlow, Mrs. Ernest E., 2611 Lovers La. 64506
Waggoner, Mrs. Sharon E., 5820 S. 3rd 64504
Weed, Mrs. Randall W., 1821 Clay 64501
Weinand, Mrs. Ernest, 2002 N. 29th 64506
Whitsell, Mrs. Ora Earl, 2306 Sacramento 64507
Willman, Mrs. Charles, 2105 Lovers La. 64505
Young, Mrs. Thomas J., 207 S. 12th, Savannah 64485

BUTLER-RIPLEY-WAYNE-CARTER COUNTIES
(Poplar Bluff 63901)

Barbour, Mrs. Marvin R., Rt. 1
Brookreson, Mrs. A. Davis, 1500 Lurlyn Rd.
Brookreson, Mrs. A. F., Rt. 6 North Main
Caldwell, Mrs. Fred, 2008 King Rd.

Carlson, Mrs. E. C., 1260 Barron Rd.
Christy, Mrs. John, 1708 Sylvan Dr.
Dinelli, Mrs. Frank E., 2628 Barron Rd.
Englehardt, Mrs. Robert C., 1513 Rosendale La.
Fraser, Mrs. R. A., 1337 Meadow La.
Hansbrough, Mrs. Eugene T., Lurlyn Rd.
Hecker, Mrs. Joseph E., 2019 Woodhaven
Hoja, Mrs. W. Alexander, Rt. 7, Box 273
Hunt, Mrs. John, Rt. 6
Kelley, Mrs. Kenneth H., 2036 King Rd.
Laatsch, Mrs. Robert H., 13333 Meadow La.
Ladyman, Mrs. George H., 1403 Lurlyn
Markel, Mrs. A. D., 2105 Jackson Rd.
McLane, Mrs. Jerry F., 2107 Jackson Rd.
Miller, Mrs. David V., Rt. 7, Box 427
Parker, Mrs. Arthur C., Jr., 708 Selma
Ramirez, Mrs. Ricardo, 2022 King Rd.
Raper, Mrs. Charles A., Rt. 2, Box 178
Reddy, Mrs. A. N., 2133 Sunset
Reddy, Mrs. S. K., 2630 N. 14th
Robertson, Mrs. William D., 900 North
Ruff, Mrs. T. Eugene, 1411 Rosedale
Shriver, Mrs. R. G., 820 Oak Hill Rd.
Stubblefield, Mrs. Calvin F., V.A. Hospital
Tapp, Mrs. Ernest, 1401 Lurlyn Rd.
Till, Mrs. Bennie, 2030 Meadows Rd.
Tinsley, Mrs. Austin R., Rt. 1, Williamsville 63967
Traxel, Mrs. William L., 2624 Valley Crest
Tuma, Mrs. A. T., 1601 Big Bend Rd.
Turner, Mrs. Kirby, Rt. 2, Box 359-A
Varma, Mrs. D. K., 2506 N. Main
White, Mrs. Barry B., 2521 Park Pl.
Wood, Mrs. Tom, 2008 Schweitzer Dr.

CALLAWAY COUNTY
(Fulton 65251)

Brown, Mrs. John J., 1304 N. Vine
Cremer, Mrs. William J., State Hospital Dr.
Domke, Mrs. Herbert R., Rt. 2, Box 364, New Bloomfield 65063
Durst, Mrs. Henry, 1 Ivy La.
Groce, Mrs. George, 1 Bartley La.
Jackson, Mrs. Vernon, State Hospital
Osbourn, Mrs. Richard A., 803 Bradley La.
Peterson, Mrs. Donald, State Hospital #1
Ritterbusch, Mrs. James K., 2 Bartley La.
Sydow, Mrs. Henry, 1411 Kenwood Dr.
Williams, Mrs. Paul, 403 Douglas Ave.
Wood, Mrs. George F., 1700 Plaza Dr.

CAPE GIRARDEAU COUNTY
(Cape Girardeau 63701)

Alyea, Mrs. James, 1869 Drury La.
Bahn, Mrs. Charles, 2418 Brookwood
Barnes, Mrs. Seth S., 1854 Broadway
Blankenship, Mrs. Dale, 1420 Sylvan La.
Bowman, Mrs. Kirk, 1965 Robinhood Circle
Burford, Mrs. Edwin K., 2424 Terry Hill
Campbell ,Mrs. Edward, 1100 N. Henderson
Chapman, Mrs. Jean Allen, 2506 Ford Dr.
Coulson, Mrs. Forest H., 1030 N. Henderson
Cozean, Mrs. Charles, 1548 Oak Lei
Crowe, Mrs. John, 1000 N. Henderson
Dinkins, Mrs. James, 1323 Perryville Rd.
Downey, Mrs. Patrick, 3218 Kage Hills Dr.
Dzur, Mrs. James, 2919 Independence
Edwards, Mrs. Don, 2530 Jonquil La.
Elrod, Mrs. Dennis B., 2500 Fairlane
Essmeyer, Mrs. Joe, Rt. 2, Box 533A
Herbert, Mrs. Charles, 648 Sylvan La.
Holcomb, Mrs. John K., Rt. 1
Horn, Mrs. Paul, 1909 Huntington
Hunt, Mrs. Robert S., 2021 Sherwood Dr.
Jaeger, Mrs. J. M., Shady Lane, Jackson (Mo.) 63755
Johnson, Mrs. Earl Wayne, 1044 N. Henderson
Johnson, Mrs. E. D. Jack, 1742 Lake Shore Dr.
Jones, Mrs. David, 2208 Brookwood
Jung, Mrs. Christopher, Rt. 2, Twin Lakes
Jung, Mrs. Marshall, Box 427, Illmo (Mo.) 63754
Kasten, Mrs. Melvin C., 1209 Sailor Circle
Kinder, Mrs. James, Rt. 1, Box 135
Kinder, Mrs. Jerry L., 2426 Brookwood
Koldys, Mrs. Kenneth, 2460 Fairview
Kratz, Mrs. Paul, 1720 Cecilia
Lovinggood, Mrs. Thomas, 2505 Allendale Dr.
Magaletta, Mrs. George, 957 Rodney Dr.
McDonald, Mrs. Eugene, 225 W. Main
McGinty, Mrs. Charles, 2819 Gordonville Rd.
Nunnelly, Mrs. Gordon, 1432 Themis
Oehler, Mrs. William, 1001 N. Henderson
Otto, Mrs. Thomas, 511 Alta Vista
Parsons, Mrs. D. L., Chateau Oaks
Rapp, Mrs. Harold, 1011 N. Henderson
Rawlins, Mrs. Fred, 1607 Bertling
Ridings, Mrs. Harold, 660 Sylvan La.
Ritter, Mrs. Carl, 1257 Rockwood
Ritter, Mrs. C. J., 2028 Concord
Ritter, Mrs. Raymond A., 2408 Terry Hill
Roberts, Mrs. Perry, 1922 Sherwood
Seabaugh, Mrs. Loy, 811 E. Rodney
Shoss, Mrs. Milton, 1222 W. Cape Rock Dr.
Sparkman, Mrs. Thomas, 1629 Oxford Dr.
Spence, Mrs. Paul, 2530 Timber La.
Stewart, Mrs. Wendell, 2550 Allendale
Talbert, Mrs. Clifford R., 2747 Jewel Dr.
Terry, Mrs. James W., 2122 Woodhaven
Tygett, Mrs. Joe, 2112 Woodhaven
Weeks, Mrs. George, 1814 Scott's La.
Wilson, Mrs. Charles, Oak Lei Dr.
Wolff, Mrs. Paul, 90 E. Cape Rock Dr.

CLAY COUNTY
(Kansas City)

Adair, Mrs. Richard F., 1009 Lancelot Dr., Liberty 64068
Adams, Mrs. Howard, 1905 Snow Drop Circle, Liberty 64068
Allan, Mrs. James, 1015 Forest La., Liberty 64068
Allen, Mrs. Louis, 501 S. Woodland Dr. 64118
Armstrong, Mrs. Jay H., 4812 Black Swan Dr., Shawnee Mission Ks. 66216
Arst, Mrs. Herbert E., 1201 N.E. 81st 64118
Balhuizen, Mrs. John, 600 N.W. 42nd Terr. 64116
Bates, Mrs. G. Comer, 102 N.E. 43rd 64116
Beeks, Mrs. John W., 1645 Sunvale Dr., Olathe, Kan. 66061
Benson, Mrs. Larry E., 3600 Appletree La. 64119
Boone, Mrs. Daniel C., 5800 N. Grand 64116
Bowles, Mrs. Richard, 414 N. Ridge, Liberty 64068
Burk, Mrs. E. K., 630 N.W. 42nd Terr. 64116
Castillo, Mrs. Michael E., 530 N.W. 43rd Terr. 64116
Chastain, Mrs. Maurice W., 3 N.E. 47th 64116
Chiles, Mrs. David R., 405 Maple, Smithville 64089
Curnow, Mrs. Richard B., 1516 Nancy La., Liberty 64068
Del Muro, Mrs. F., 5902 Poplar Dr. 64118
Denton, Mrs. Robert, 716 Manzonola, Smithville 64089
Demoncourt, Mrs. John, 603 Quincy, Smithville 64089
Devine, Mrs. Mark W., 6910 Overhill Rd., Shawnee Mission, Kan. 66208
Dolan, Mrs. C. Terrance, Rt. 2, Smithville 64089
Dy-Ragos, Mrs. Ramon R., 5432 N.W. 70th 64151
Edwards, Mrs. Theodore F., 512 N.W. 43rd Terr. 64116
Falter, Mrs. Richard, 4705 N.W. 81st St. Terr. 64151
Fakhoury, Mrs. Donald A., 4332 N. Central 64116
Fischer, Mrs. Jose, 8515 W. 71st, Shawnee Mission, Kan. 66204
Flanders, Mrs. Virgil E., 2022 W. 91st, Leawood, Kan. 66206
Fotopoulos, Mrs. Chris K., 2917 Cheyenne Circle, No. Kansas City 64116
Fowler, Mrs. I. Charles, 700 E. Barnes Ave. 64118
Gauer, Mrs. Robert J., 525 N.W. 43rd Terr. 64116
Haley, Mrs. Ted M., 4121 N. Briarcliff Rd. 64116
Hayes, Mrs. Lawrence L., 440 N. Woodland Dr. 64118
Hedges, Mrs. Richard C., 1017 Southwind Dr., Excelsior Springs 64024
Hodge, Mrs. Robert H., 2204 N.E. 39th 64116
Huddleston, Mrs. Harvey, 6 Marisa , Smithville 64089
Ise, Mrs. Frank, 6700 W. 66th Terr. Shawnee Mission, Kan. 66202
King, Mrs. Phillip, 529 Fairview, Liberty 64068
Kirkland, Mrs. Jerry, 6604 N.W. Overland Dr. 64151
Kuenzi, Mrs. Donald E., 924 S. Woodland Dr. 64118
Langhus, Mrs. Melvin O., 104 N.W. Englewood Rd. 64118
Lanning, Mrs. R. James, 3801 N. Central 64116
Latimer, Mrs. Walter N. A., 4915 N. Kansas 64119
Littlejohn, Mrs. Robert, 5215 W. 63rd Terr., Shawnee Mission, Kan. 66208
McCluggage, Mrs. Newt C., 418 N.W. 43rd Terr. 64116
McCormick, Mrs. James E., 309 Northcrest Dr. 64116
McPhee, Mrs. William R., 1205 W. 76th 64114
Myers, Mrs. David W., 201 E. Summit, Smithville 64089
Parker, Mrs. Robert H., 112 N.E. 43rd 64116
Patterson, Mrs. Carroll D., 626 N.W. 42nd Terr. 64116
Perico, Mrs. Carlos, 8729 Rosewood, Prairie Village, Kan. 66207
Pileggi, Mrs. Felix A., 424 N.W. Briarcliff Rd. 64116
Purcell, Mrs. Paul, 4 Carver, Smithville 64089
Reeder, Mrs. Charles C., 3 Maple Circle, Smithville 64089
Revare, Mrs. Paul, 3245 Chippewa Dr. 64116
Robinson, Mrs. Van M., 415 N.W. Briarcliff Ct. 64116
Schertz, Mrs. Truman, 428 N.W. Briarcliff Rd. 64116
Schultz, Mrs. Robert, 1532 N. Withers Rd., Liberty 64068
Schutz, Mrs. John P., 304 Virginia, Excelsior Springs 64024
Slaughter, Mrs. Carl, 1001 N. Woodland 64118
Smith, Mrs. Charles H., 6203 Circle Dr. 64118
Somoza, Mrs. Jose, 15 N.E. Hill 64116
Soper, Mrs. William, 203 Garden La., Excelsior Springs 64024
Spelman, Mrs. Arch E., 500 N. Bridge, Smithville 64089
Sportsman, Mrs. Weldon L., Rt. 2, Smithville 64089
Stratman, Mrs. Clarence A., 405 N.W. 53rd 64118
Thomas, Mrs. Anthony, 940 N. Woodland Dr. 64118
Triplett, Mrs. Daniel A., 936 Scott Dr., Liberty 64068
Underwood, Mrs. J., III, 3529 N.E. 48th Terr. 64119
Vilmer, Mrs. Charles E., 6209 W. 65th, Shawnee Mission, Kan. 66202
Wald, Mrs. Donald, 1608 N.E. 69th 64118
Waltz, Mrs. Charles A., 1010 N. Woodland Dr. 64118
Waterman, Mrs. Franklin M., 420 Glendale Rd., Liberty 64068
Werner, Mrs. Dean F., 4609 N. Main 64116
Werner, Mrs. Franklin C., 422 Sagamore La. 64116
Williams, Mrs. R. D., 6533 Rainbow, Shawnee Mission, Kan. 66208
Withrow, Mrs. John B., 3925 N. Main 64116
Workman, Mrs. Charles E., 6609 Milhaven Dr., Shawnee Mission, Kan. 66202
Wright, Mrs. Earl, 8196 N.W. Kirkwood Dr. 64151

COLE COUNTY
(Jefferson City 65101)

Allen, Mrs. James E., 846 Crestmere
Beldon, Mrs. E. A., 2124 Lowell
Bradley, Mrs. William, 1705 Greenberry Rd.
Bowe, Mrs. Ted, 2503 Shellridge Dr.
Bregant, Mrs. Robert, 3435 Country Club Dr.
Busby, Mrs. William E., 523 Mesa
Cooper, Mrs. Charles W., 508 E. Miller
Courter, Mrs. Larry, Rt. 4
Cox, Mrs. William A., 812 Swifts Highway
Davisson, Mrs. Walter F., Star Rt. 1, Schott Rd.
Doerhoff, Mrs. Alan, Shepherd Hills
Dorris, Mrs. Richard P., 1611 Ridgewood
Enloe, Mrs. L. David, 1200 Moreland
Exon, Mrs. C. Stuart, 916 Boonville
Files, Mrs. James, 330 Sterling Price Rd.
Fullgrabe, Mrs. Emil A., 1914 Green Meadow Dr.
Garner, Mrs. Lynn M., 403 Meier Dr.
Garner, Mrs. Royal, Holts Summit, 65043
Giffen, Mrs. Lawrence E., 1915 Hayselton Dr.
Gordon, Mrs. James, 600 Boonville Rd.
Gove, Mrs. Herman S., 712 Broadway
Guhleman, Mrs. Henry V., Jr., 2018 Greenberry Rd.
Gurnee, Mrs. Landon H., 2941 Country Club Dr.

Handler, Mrs. Fred P., 614 Boonville Rd.
Hauser, Mrs. Robert J., Schott Rd.
Kanagawa, Mrs. Harold Hajime, 816 Houchin
Kanagawa, Mrs. Harold K., 314 Crest Dr.
Kelly, Mrs. Marshall W., 1916 Greenberry Rd.
Klebba, Mrs. Larry B., 3300 Country Club Dr.
Leslie, Mrs. James T., Jr., 1824 Brookside Blvd.
Loyd, Mrs. Earl L., Riviera Heights
Matthews, Mrs. John I., 1314 Moreau Dr.
McHaney, Mrs. John W., 1819 Brookside
McKnelly, Mrs. William V., 1106 Lee
Meier, Mrs. Francis X., 1913 Hayselton Dr.
Meinershagen, Mrs. Charles W., 138 Forest Hill
Ossman, Mrs. Julian A., 2407 W. Main
Ringo, Mrs. Henry, Centertown 65023
Robb, Mrs. Harold P., 1117 Leslie Blvd.
Russell, Mrs. Joseph P., 1717 Greenberry Rd.
Ryan, Mrs. Thomas J., 1109 Moreau Dr.
Sanders, Mrs. Jack Shelby, 1820 Brookside Blvd.
Schmidt, Mrs. Jerome H., 806 Boonville
Schokker, Mrs. Johannes, 3463 Hobbs La.
Scott, Mrs. David, 957 Westwood
Sennott, Mrs. John Stephen, 123 Douglas Dr.
Shull, Mrs. G. Donald, 1925 Hayselton Dr.
Sicat, Mrs. Alfonso V., 414 Ladue
Siu, Mrs. Kenneth C., 1009 Fairmount Blvd.
Stauffer, Mrs. Harry Beach, 830 Boonville Rd.
Stricker, Mrs. Harold C., Rt. 5, Zion Rd.
Sugarbaker, Mrs. Everett D., 2113 W. Main
Summers, Mrs. Joseph S., Jr., 2312 W. Main
Tanner, Mrs. Robert H., 1910 Greenberry Rd.
Taylor, Mrs. Leon A., 1104 W. Main
Tietjen, Mrs. Fred C., 7 Greentree Rd.
Van Vranken, Mrs. Eugene E., 2037 Tower Dr.
Wallace, Mrs. John K., 220 Ridgeway
Watts, Mrs. Byron Edward, 2112 Forest Dr.
Werth, Mrs. Joseph A., 325 Old Gibler Rd.
Westhoff, Mrs. D. Douglas, 2616 Schellridge Rd.

COOPER COUNTY
(Boonville 65233)

Abele, Mrs. William A., Krohn Dr.
Avery, Mrs. Willard B., 10 Oak Valley Rd.
Diekroeger, Mrs. Manuel L., Rt. 2
Hata, Mrs. Daikichi, 7 Morningside Dr.
Humphreys, Mrs. Edward T., 1123 Third St.
Stuart, Mrs. Byron M., 910 Shamrock Terr.
Winn, Mrs. George W., 607 Poplar
Ziegler, Mrs. William H., Weyland Dr.

DUNKLIN COUNTY
(Kennett 63857)

Benson, Mrs. Leo J., Jr., 204 Wiggs
Cash, Mrs. Charles R., 1112 White Oak Pl.
Croom, Mrs. D. W., Malden 63863
Dunmire, Mrs. George, 504 S. Baker Dr.
Huang, Mrs. J. S., 1932 Preston
Legan, Mrs. John K., 617 Butler Dr.
Miltenberger, Mrs. Paul C., 705 W. Washington
Moorehead, Mrs. William E., Malden 63863
Palenske, Mrs. R. L., Hornersville 63855
Peck, Mrs. C. R., 234 S. Main
Pu, Mrs. Pin H., 1105 W. Eighth
Santos, Mrs. R. J., 1106 Kenwood
Sisler, Mrs. Maynard, 411 Michael
Tarver, Mrs. Quinton, 1004 W. Washington
Wilson, Mrs. L. C., 915 S. Jackson
Zimmerman, Mrs. Joe A., 1105 White Oak Pl.

FRANKLIN-GASCONADE-WARREN COUNTIES

Baker, Mrs. Donald, 900 Clearview Dr., Union 63084
Bonney, Mrs. Samuel C., 2 Southpoint Pl., Washington 63090
Bozzo, Mrs. Raymond J., 6 Catawba Pl., Washington 63090
Brenner, Mrs. Paul A., 108 W. Washington, Owensville 65066
Eisenmann, Mrs. Benjamin B., New Haven 63068
Farrell, Mrs. S. L., 205 Elm, Washington 63090
Hoelscher, Mrs. H. F., Hickory Haven, Warrenton 63383
Moellenhoff, Mrs. Robert, 2315 E. Fifth, Washington 63090
Muench, Mrs. Ludwig O., 1530 Riverview Dr., Washington 63090
Post, Mrs. John R., Post Dr., Washington 63090
Richardson, Mrs. G. A., 1 East Lane, Union 63084
Schmodt, Mrs. Charles, Box 143, Gerald 63067
Strehlman, Mrs. Benjamin G., 510 West End Union 63084

GRAND RIVER COUNTIES
(Caldwell, Carroll, Livingston, Grundy Davies, Harrison, Linn, Mercer & DeKalb Counties)

Allen, Mrs. E. W., 1202 N. Jefferson, Carrollton 64633
Atcheson, Mrs. Windsor, 108 Kavanaugh, Trenton 64683
Bales, Mrs. Eugene, 502 W. Third Terr., Carrollton 64633
Bohnsack, Mrs. Ralph, 635 Skyline Dr. Brookfield 64628
Broyles, Mrs. Watkins, Bethany 64424
Conrad, Mrs. Joseph, 1202 Jackson, Chillicothe 64601
Cofer, Mrs. Thomas N., 503 Elmdale, Chillicothe 64601
Cross, Mrs. Albert, 1903 Moberly Rd., Trenton 64683
Daley, Mrs. Frank, 508 E. Samuel, Hamilton 64644
Dixon, Mrs. John, 1005 Brookfield, Brookfield 64628
Dowell, Mrs. Donald, 1830 Calhoun, Chillicothe 64601
Ellsworth, Mrs. Willard, Cainsville 64632
Fair, Mrs. William, 1705 Calhoun, Chillicothe 64601
Gale, Mrs. Joseph, 1710 Polk, Chillicothe 64601
Galvez, Mrs. Sisenando P., Santa Fe, Marceline 64658
Gearhart, Mrs. Merriam, 2100 Beekman, Bethany 64424
Howell, Mrs. Billy, Rt. 1, St. Catherine 64677
Mandler, Mrs. George, 1616 Clay, Chillicothe 64601
Platz, Mrs. John, 804 N. Main, Carrollton 64633
Rose, Mrs. John F., 1024 Grandview, Chillicothe 64601
Ryan, Mrs. David, 1808 Hillcrest, Trenton 64683
Trinidad, Mrs. Hermanito, 1324 Dorney Dr., Chillicothe 64601
Vandiver, Mrs. V. D., Rt. 2, Chillicothe 64601
Yoon, Mrs. Jin S., 1500 Burnam Rd., Chillicothe 64601

GREENE COUNTY
(Springfield)

Allen, Mrs. Jerry H., 1324 S. Fairway Terr. 65804
Allison, Mrs. James B., 2507 S. Luster 65804
Ancheta, Mrs. Apolinario, 1417 E. Hanover, 65804
Anthony, Mrs. Dallas D., 1322 S. Pickwick, 65804
Ash, Mrs. Charles J., 743 Riverside 65807
Ashley, Mrs. Thomas E., 2740 Pythian 65802
Atkinson, Mrs. Thomas E., Rt. 9, Box 81A 65804
Auner, Mrs. Cecil R., 649 McCann 65804
Back, Mrs. Donald K., 2852 S. Glendale 65804
Baldwin, Mrs. Richard M., 2033 Prairie La. 65804
Barnhill, Mrs. Floyd, 3215 Bellhurst 65804
Beisner, Mrs. Don, 1512 Charing Rd. 65804
Benson, Mrs. Ronald, 4372 Valley Dr. 65804
Berry, Mrs. Paul T., 2135 Shady Glen 65804
Blades, Mrs. Ross, 2308 Barataria 65804
Bonebrake, Mrs. McDonald D., 1443 S. Delaware 65804
Boone, Mrs. Martin, Rt. 2, Box 315 65802
Borja, Mrs. E. R., 2912 S. Brentmoor 65804
Brent, Mrs. Lanny, 4430 S. Pratt 65804
Broaddus, Mrs. Loren, 2425 Barataria 65804
Brown, Mrs. David, 2911 Melbourne Rd. 65804
Brown, Mrs. Lyman, 1410 N. Rogers 65802
Burkey, Mrs. Jordon W., 2405 Sheridan 65804
Busiek, Mrs. Urban J., 1635 E. Walnut 65802
Callaway, Mrs. Guy, 901 E. Portland 65804
Carr, Mrs. Phillip, 1260 E. Catalpa, 65804
Cheek, Mrs. Anne C., 1535 E. Meadowmere 65804
Cheek, Mrs. James W., 2342 Fritts La. 65804
Christy, Mrs. Raymond, Jr., 2738 S. Marlan 65804
Ciccone, Mrs. Pasquale, U. S. Medical Center 65804
Clarke, Mrs. Michael, Rt. 1, Box 422-A 65803
Clary, Mrs. William, 2224 Edgewater 65804
Cochran, Mrs. Thomas E., 2423 Brentwood Blvd. 65804
Conrad, Mrs. R. C., 1338 S. Delaware 65804
Cooper, Mrs. C. Wesley, 2266 S. Inglewood
Cordonnier, Mrs. James K., 2320 E. Rosebriar
Corry, Mrs. Francis, 2461 Catalina 65804
Cox, Miss Eleanor, 1072 Roanoke 65804
Crawford, Mrs. Oral, Rt. 1, Box 443 65803
Crighton, Mrs. John C., 3419 Weaver Rd. 65804
Danielsson, Mrs. Ernest P., 3324 E. Redbud La. 65807
Dillard, Mrs. Erin M., Rt. 9, Box 425B 65804
Dolan, Mrs. Daniel L., 2413 Claremont 65804
Domann, Mrs. Darrel, 4305 Ridgeview Rd. 65804
Duncan, Mrs. Robert D., 1234 E. Loren 65804
Edison, Mrs. John M., 3164 Belhurst 65804
Elkadi, Mrs. Ahmed, 2524 Barataria 65804
Ellis, Mrs. Francis J., 2235 E. Glenwood 65804
Ellis, Mrs. Harry L., 2375 E. Rosebrier 65804
Evans, Mrs. E. L., 2457 E. Barataria 65804
Farthing, Mrs. Gene W., 1235 E. Walnut 65802
Ferguson, Mrs. John P., 1219 S. Clay 65804
Fessenden, Mrs. Ersel M., 634 E. Kingsbury 65804
Fitch, Mrs. Max, Rt. 1, Box 285, Brighton 65617
Fogle, Mrs. Phillip, 2140 S. Meadowview 65804
Francis, Mrs. William C., 2820 E. Glenwood 65804
Freeman, Mrs. S. F., 1339 S. Pickwick 65804
Gaska, Mrs. Walter, 2503 Collinson 65804
Gentry, Mrs. Michsel A., 2151 E. Rosebrier 65804
Gerdes, Mrs. John, 3041 Lamonta 65804
German, Mrs. Walter A., 2971 Southern Hills Blvd. 65804
Giddings, Mrs. Frank C., 1211 S. Pickwick 65804
Giffin, Mrs. James, Rt. 2, Box 91 65802
Glynn, Mrs. Robert, 1101 Benton 65802
Gorelick, Mrs. David F., 1041 Linwood Terr. 65807
Gose, Mrs. Don F., 1339 S. Delaware 65804
Hall, Mrs. David, Rt. 2, Rogersville 65742
Hall, Mrs. Durward G., 2442 S. Fremont 65804
Hamburg, Mrs. Fredrick, 2757 E. Normandy 65804
Harmon, Mrs. Ben C., Rt. 1, Nixa 65714
Harvey, Mrs. Harold D., 2531 Brentwood 65804
H'Doubler, Mrs. Alice, Rt. 7, Box 207 65802
H'Doubler, Mrs. Charles E., 1421 Bedford Rd. 65804
H'Doubler, Mrs. F. T., Jr., 2445 Melbourne Rd. 65804
H'Doubler, Mrs. Peter B., 1137 S. Pickwick 65804
Herfkens, Mrs. Kenneth, 2818 Natural Bridge 65804
Hills, Mrs. Joe E., 2917 Natural Bridge 65804
Hinds, Mrs. Paul A., Rt. 5, Box 532 65803
Holland, Mrs. Robert, 2225 E. Edgewood 65804
Hollis, Mrs. Richard, 2236 S. Inglewood 65804
Holmes, Mrs. Daniel E., Rt. 9, 4318 Sunset 65804
Holmes, Mrs. David R., 2539 Melbourne Rd. 65804
Huewe, Mrs. Douglas H., 2204 Claiborne 65804
Jobe, Mrs. Charles, 2415 E. Edgewood 65804
Johnson, Mrs. Fritz, 2435 E. Cambridge 65804
Johnson, Mrs. Warford, 2244 Edgewood 65804
Johnson, Mrs. George, 2349 Edgewood 65804

Johnson, Mrs. William F., 973 E. Linwood Dr. 65807
Johnston, Mrs. Joseph L., 2855 Southern Hills 65804
Jones, Mrs. Harold L., 3042 Ridge Dr. 65804
Key, Mrs. James S., 2278 Inglewood 65804
Kipfer, Mrs. Robert, 4328 S. Pratt 65804
Klingner, Mrs. George M., Turners 65765
Klingner, Mrs. George M., Jr., Rt. 3, Box 202, Rogersville 65742
Knabb, Mrs. Kenneth E., 1229 E. Catalpa 65804
Kolze, Mrs. Vernon, 2519 S. Marlan 65804
Krahn, Mrs. Henry, 1415 Essex 65804
Langston, Mrs. W. Roland, 1453 S. Fairway 65804
LeFevre, Mrs. Philip, 2851 E. Covington Circle 65804
Lemmon, Mrs. G. Bruce, 1462 Virginia 65807
Lewis, Mrs. Noel R., Rt. 1, Strafford 65757
Litton, Mrs. Lyle, 3044 Shalimar 65804
Lockhart, Mrs. Charles E., 1600 E. Catalpa 65804
Loeb, Mrs. Richard, 4133 E. Ridge Dr. 65804
Lorenc, Mrs. Ernest, 2819 Canyon Dr. 65804
Lovett, Mrs. Robert L., 2850 Versailles 65804
Lowe, Mrs. Arch, 1700 E. Walnut 65802
Lowell, Mrs. James, 3535 Primrose Ct. 65807
Lurie, Mrs. Harold, 2440 Skyline Dr. 65804
Maddux, Mrs. William, 2634 Inglewood Rd. 65804
Maple, Mrs. Francis M., 2115 Edgewood 65804
Maples, Mrs. Ruth, 885 S. Salt Pond, Apt. 1A, Marshall 65340
McAlhany, Mrs. Howard J., 1643 E. Catalpa 65804
McKinsey, Mrs. John, 2802 Natural Bridge 65804
McLaughlin, Mrs. Richard, 1021 E. Woodland 65807
Menchetti, Mrs. Don E., Rt. 9, Box 425A 65804
Mentgen, Mrs. Carl, 5759 Wildwood Circle-S Dr. 65804
Michael, Mrs. Harvey R., 2847 S. Chantilly 65804
Milne, Mrs. Jay L., 2947 Whiteoak Dr., Rt. 9 65804
Moore, Mrs. DeArmand, 2306 S. Meadowview 65804
Moseley, Mrs. F. Thomas, 2837 Lomita Circle 65804
Napper, Mrs. Marvin, Rt. 1, Box 80-A, Ash Grove 65604
Neu, Mrs. Leo T., 3008 Carlisle Circle 65804
Olson, Mrs. E. Rule, 2645 Wildwood Rd. 65804
Overend, Mrs. Don F., 3020 Ridge Dr. 65804
Palcheff, Mrs. Chris L., Rt. 9, Box 400L 65804
Park, Mrs. William I., 815 E. Portland 65804
Parlato, Mrs. George, 2204 Shady Glen 65804
Penninger, Mrs. William H., 2246 Claiborne 65804
Peterson, Mrs. Stanley S., 721 E. Stanford 65807
Powell, Mrs. Edwin, 1226 S. Weller 65804
Prater, Mrs. Bill George, 3000 Carlisle Circle 65804
Pruett, Mrs. Paul L., Rt. 9, Box 425 65804
Quinn, Mrs. Paul, 2857 Chantilly 65804
Robinson, Mrs. Gary L., 2725 S. Patterson 65804
Sala, Mrs. Jose M., 2901 Utica 65804
Sammon, Mrs. T. James, 1526 S. Devon 65804
Sauer, Mrs. Paul, Rt. 11, Box 2325 65803
Schaeffer, Mrs. Edward, 2356 Wildwood Circle 65804
Schreiber, Mrs. Norman, 3754 E. Cherry 65804
Schroff, Mrs. Carle H., 2448 E. Broadmoor 65804
Schwartz, Mrs. Eugene J., 1315 E. Loren 65804
Schweitzer, Mrs. Fred C., 2550 S. Luster 65804
Shakter, Mrs. Bruce, 1538 Essex 65804
Shane, Mrs. Ramon, 2910 Wildwood Rd. 65804
Shelton, Mrs. R. Wayne, 1251 E. Linwood 65804
Siceluff, Mrs. Joseph G., 609 Cherry 65806
Silsby, Mrs. Don J., 1054 Linwood Circle 65807
Simpson, Mrs. E. L., 2133 Meadowview 65804
Snead, Mrs. William H., 2532 Sheridan 65804
Sponenberg, Mrs. Don, 2905 Versailles 65804
Stamatis, Mrs. John J., 2875 S. Rochelle 65804
Stewart, Mrs. Robert B., 2360 E. Grand 65804
Stufflebaum, Mrs. Robert E., 2323 E. Rosebrier
Sturtevant, Mrs. Harwood No., 2859 Utica 656804
Sullivan, Mrs. Dan T., 2241 Cherryvale 65804
Sundstrom, Mrs. Frank D., Rt. 1, Ozark 65721
Suva, Mrs. Morfeo M., 1915 E. Swallow 65804
Sweeney, Mrs. Thomas, Rt. 1, Nixa 65714
Tarrasch, Mrs. Ernest, 2114 Langston 65804
Terry, Mrs. James F., Jr., 2830 Chambery 65804
Thomasson, Mrs. David D., 2311 E. Glenwood 65804
Tillman, Mrs. Walter, 1220 E. Loren 65804
Tombridge, Mrs. T. L., 2830 S. Marlan 65804
Tsang, Mrs. John, 3514 E. Cherry 65804
Trotter, Mrs. W. Yates, 1243 E. Catalpa 65804
Turner, Mrs. Glenn O., 1462 S. Dollison 45804
Upshaw, Mrs. Paul, 2118 S. Fairway 65804
Vensel, Mrs. Lee H., Jr., 2255 Meadowview 65804
Waddell, Mrs. Kenneth, 1126 S. Kentwood 65804
Wakeman, Mrs. J. Newton, 1402 Meadowmere 65804
Wakeman, Mrs. J. Newton, Jr., 2251 E. Washita 65804
Walker, Mrs. William M., 2845 Southern Hills Bld. 65804
Wantuck, Mrs. Donald, 3324 Wellwood 65804
Warren, Mrs. William, Rt. 1, Ava 65608
Warres, Mrs. Herbert L., 2614 Englewood Rd. 65804
Waterfield, Mrs. Jim, 2565 Sheridan Blvd. 65804
Webb, Mrs. Richard, 1243 E. Loren 65804
White, Mrs. R. Ned, 3634 Cherry 65804
Williams, Mrs. John W., 2245 Fritts La. 65804
Wilson, Mrs. Roy E., Rt. 1, Box 210-A, Rogersville 65742
Winsky, Mrs. Arlen D., 3031 E. Rocklyn 65804
Wise, Mrs. Gordon F., 2850 Southern Hills 65804
Wittmer, Mrs. Samuel C., 2314 E. Washita 65804
Wooldridge, Mrs. Wilfred E., 1126 E. Stanford 65807
Wyrsch, Mrs. Leo M., 2222 Meadowview
Yancey, Mrs. Daniel L., 1133 S. Weller 65804
Zahn, Mrs. Robert, 1030 Brookside 65807

JACKSON COUNTY
(Kansas City)

Abella, Mrs. Ben Z., 8967 E. 62nd Terr. 64133
Abrams, Mrs. Bernard M., 1021 W. 69th 64113
Adelman, Mrs. Arthur, 6305 Aberdeen, Shawnee Mission, Kan. 66208
Agee, Mrs. Loren Glenn, Rt. 1, Rantoul, Kan. 66079
Aks, Mrs. Daniel, 3100 W. 68th, Shawnee Mission, Kan. 66208
Alderman, Mrs. Donald, 3221 W. 83rd, Leawood, Kan. 66206
Alderman, Mrs. Thomas F., 309 E. 127th 64145
Allebach, Mrs. Hobart K., 3020 W. 84th Pl., Leawood, Kan. 66207
Ammatelli, Mrs. F. J., 1235 W. 57th Terr. 64113
Andrus, Mrs. Bailey C., 6508 Overbrook Rd., Shawnee Mission Kan. 66208
Arbab, Mrs. Ali A., 2415 W. 67th, Shawnee Mission, Kan. 66208
Arms, Mrs. Arnold V., 302 W. 99th Terr. 64114
Arribas, Mrs. Romeo, 708 Range, Blue Springs 64105
Ashcroft, Mrs. Keith A., 6700 High Dr., Shawnee Mission, Kan. 66208
Atcheson, Mrs. Bellfield, 2011 W. 70th Terr., Shawnee Mission, Kan. 66208
Atwell, Mrs. Floyd C., 630 W. 60th Terr. 64113
Bachman, Mrs. Paul L., 1206 W. Truman Rd., Independence 64050
Baer, Mrs. Alvin J., 5800 Howe Dr., Shawnee Mission, Kan. 66205
Balanoff, Mrs. Arnold Z., 2500 W. 71st, Shawnee Mission, Kan. 66208
Ballard, Mrs. V. Bryce, 6618 Rainbow, Shawnee Mission, Kan. 66208
Barelli, Mrs. Pat A., 5609 Mission Dr., Shawnee Mission, Kan. 66208
Barloon, Mrs. James H., 2109 W. 70th, Shawnee Mission, Kan. 66208
Barnard, Mrs. John L., 825 W. 52nd 64112
Barr, Mrs. Glenn A., 9615 Grandview Rd. 64137
Barry, Mrs. John W., 5510 W. 84th, Shawnee Mission, Kan. 66207
Barry, Mrs. William B., Sulgrave Apts., 121 W. 48th 64112
Basantz, Mrs. F. Victor, 2025 W. 91st, Shawnee Mission, Kan. 66206
Bass, Mrs. Walter R., 6415 Sterling 64133
Bauer, Mrs. Lafe W., 4818 W. 80th, Prairie Village, Kan. 66208
Bayer, Mrs. William, 1256 W. 59th 64113
Beall, Mrs. M. S., 9029 High Dr., Shawnee Mission, Kan. 66206
Beatty, Mrs. Eugene C., 4923 W. 96th Terr., Shawnee Mission, Kan. 66207
Becker, Mrs. Rolphe A., 6501 Wenonga, Shawnee Mission, Kan. 66208
Behrenda, Mrs. Steven H., 5420 Cedar, Shawnee Mission, Kan. 66208
Bell, Mrs. William F., 214 Oxford La., Lee's Summit 64063
Bennett, Mrs. J. D., 3216 W. 69th, Shawnee Mission, Kan. 66208
Benoit, Mrs. Hector W., 2501 W. 64th, Shawnee Mission, Kan. 66208
Benson, Mrs. William F., 1210 W. 58th 64113
Berenson, Mrs. Sheldon E., 832 W. 63rd 64113
Berry, Mrs. Maxwell G., Sulgrave Apts., 121 W. 48th 64112
Bickley, Mrs. James E., 3004 W. 83rd Terr., Leawood, Kan. 66206
Biggs, Mrs. Alfred D., Jr., 6551 Wenonga Terr., Shawnee Mission, Kan. 66208
Bikales, Mrs. Victor W., 5810 High Dr., Prairie Village, Kan. 66208
Bishop, Mrs. Francis, 3208 W. 83rd Terr., Leawood, Kan. 66206
Black, Mrs. Eugene C., 3201 W. 67th, Shawnee Mission, Kan. 66208
Black, Mrs. Thomas C., 7929 Outlook, Shawnee Mission, Kan. 66208
Blim, Mrs. Richard Don, 2209 W. 68th, Shawnee Mission, Kan. 66208
Bohan, Mrs. Peter T., 4545 Wornall Rd. 64111
Bordy, Mrs. Marvin D., 1911 Romany Rd., Shawnee Mission, Kan. 66208
Borenstine, Mrs. Joseph, 7307 Holmes 64131
Borsuk, Mrs. Gregory M., 16525 E. 36th, Independence 64055
Bowser, Mrs. John F., 3701 Madison 64111
Boyd, Mrs. George K., 4810 W. 80th, Shawnee Mission, Kan. 66208
Boylan, Mrs. Peter C., 3308 W. 87th, Shawnee Mission, Kan. 66206
Braby, Mrs. Howard, 512 Linwood Terr., Independence 64050
Brams, Mrs. Jack B., 5050 Oak St. 64112
Braverman, Mrs. Abe Elliott, 2710 W. 68th, Shawnee Mission, Kan. 66208
Brick, Mrs. Jeffrey, 3012 W. 83rd Terrace, Shawnee Mission, Kan. 66206
Brower, Mrs. Clyde, 118 S. Willis, Independence 64050
Brown, Mrs. Adrian J., 12 E. 63rd 64113
Brown, Mrs. Elwyn S., 200 W. 115th 64114
Brown, Mrs. Menzie H., 9421 Ralston 64134
Brown, Mrs. William R., 8717 Rosewood Dr., Shawnee Mission, Kan. 66207
Brumm, Mrs. L. W., 7421 Wyoming 64114
Buckner, Mrs. Robert C., 3507 W. 87th, Leawood, Kan. 66206
Budke, Mrs. Harold A., 1219 W. 66th Terr. 64113
Buhler, Mrs. Victor B., 5212 Bellview 64112
Bunting, Mrs. Williston P., 1231 W. 62nd 64113

Caffrey, Mrs. Raymond J., 1314 W. Red Bridge Rd. 64114
Calowich, Mrs. Emery, 3500 W. 49th, Shawnee Mission, Kan. 66205
Camacho, Mrs. Homero, 10505 Wedd, Overland Park, Kan. 66212
Campbell, Mrs. Frederick B., 1032 W. 55th 64113
Campbell, Mrs. John, 429 W. 69th 64113
Capps, Mrs. Eugene C., 7921 El Monte, Shawnee Mission, Kan. 66208
Carder, Mrs. George A., 1011 Scott Dr., Liberty 64068
Carlson, Mrs. Hjalmar E., 2709 W. 66th, Shawnee Mission, Kan. 66208
Carmichael, Mrs. Francis A., 5841 High Dr.. Shawnee Mission, Kan. 66208
Carrier, Mrs. Ed, 2410 W. 64th, Shawnee Mission, Kan. 66208
Caruso. Mrs. Alfred A., 2018 W. 70th Terr., Shawnee Mission, Kan. 66208
Case, Mrs. William F., 4913 W. 97th, Shawnee Mission. Kan. 66207
Casford, Mrs. Ralph, 1236 W. 72nd 64114
Cattaneo, Mrs. Ernest A., 9200 Cherokee La., Shawnee Mission, Kan. 66206
Chambers. Mrs. James Q., 5500 Belinder Ave., Shawnee Mission, Kan. 66205
Chandler, Mrs. Robert S., 6435 Indian La., Shawnee Mission, Kan. 66208
Chapman, Mrs. James H., 9820 Lee Blvd., Shawnee Mission, Kan. 66206
Chaudhuri, Mrs. Tepan K., 7816 Ridgeway 64138
Childs, Mrs. Richard M., 5325 Mission Woods Terr., Shawnee Mission, Kan. 66206
Chowdhury, Mrs. Dipak, 16812 Larkspur La., Independence 64055
Chung, Mrs. Richard. 4406 North Lake, Lee's Summit 64063
Clark, Mrs. Irving H., 2811 Blue Ridge Ext., Grandview 64030
Cline, Mrs. Merle A., 6115 Karen Rd. 64151
Clough. Mrs. Charles A., 5820 W. 61st Terr., Shawnee Mission, Kan. 66202
Cobb. Mrs. Sanford, 12814 Sagamore Rd., Shawnee Mission. Kan. 66209
Cockerell, Mrs. Sanford F., 3051 S. Crysler, Independence 64050
Coffey, Mrs. Ralph R., 5211 Wornall Rd. 64112
Colom, Mrs. George A., 4002 W. 56th, Shawnee Mission, Kan. 66205
Conn, Mrs. Robert, 3725 W. 64th, Shawnee Mission, Kan. 66208
Coppinger, Mrs. Thomas A., 8 E. 55th Terr. 64113
Cotton, Mrs. Thomas R., 6908 Valley Rd. 64113
Cowan, Mrs. George, Lake Quivira, Kansas City, Kan. 66106
Cox, Mrs. Kenneth E., 5640 Pembroke La., Prairie Village, Kan. 66208
Crocker, Mrs. Albert, 7512 Crisp 64138
Crouch, Mrs. Thomas T., 6800 W. 66th Terr., Shawnee Mission, Kan. 66202
Curran, Mrs. Desmond, 6626 Wenonga Terr., Prairie Village, Kan. 66208
Curts, Mrs. Calvin J., 5709 Metcalf Ct., Shawnee Mission, Kan. 66202
Dalton, Mrs. Timothy, 11841 Oak 64114
Davis, Mrs. Donald R., 2501 W. 67th, Shawnee Mission, Kan. 66208
Davis, Mrs. Herbert V., 4601 Holmes 64110
Davis, Mrs. Jack M., 7110 Harecliff Dr. 64133
DeFeo, Mrs. Theodore, 4100 W. 90th Terr., Shawnee Mission, Kan. 66207
Demott, Mrs. John D., 4402 Homestead Dr., Prairie Village, Kan. 66208
Dempsey, Mrs. Herbert A., 806 Chestnut, Lee's Summit 64063
Dennie. Mrs. Charles C., 121 W. 48th 64112
Dimond, Mrs. E. Grey, 5650 Ward Pkwy. 64113
Dixon, Mrs. George D., 10416 Mohawk La., Leawood, Kan. 66206
Dixon, Mrs. V. L., 2501 W. Paseo 64108
Dlabal, Mrs. L. J., 3729 Blue Ridge Blvd., Independence 64052
Dodge, Mrs. Mark, 5820 State Line Rd., Shawnee Mission, Kan. 66208
Dorsch, Mrs. E. H., 3807 Woodland, Independence 64052
Downey, Mrs. James W., 6909 W. 52nd Pl., Shawnee Mission Kan. 66202
Drake, Mrs. Roy F., 6600 Outlook, Shawnee Mission, Kan. 66202
Drisko, Mrs. Robert M., 2100 Stratford Rd., Shawnee Mission, Kan. 66208
Dunleavy, Mrs. James D., 11330 Madison 64114
Durie, Mrs. Robert H., 8446 Juniper La., Shawnee Mission, Kan. 66207
Durnell, Mrs. Monaford D., 308 Lincolnwood, Lee's Summit 64063
Earnest, Mrs. James B., 1250 W. 59th 64113
Edmonds, Mrs. D. D., 9009 Mission Rd., Leawood, Kan. 66206
Eiseman, Mrs. Gistave, 6520 Overhill Rd., Shawnee Mission, Kan. 66208
Elias, Mrs. David J., 22 E. Tapawingo, Blue Springs 64015
Ellfeldt, Mrs. Howard, 8544 Roe Blvd., Prairie Village, Kan. 66207
Elliott, Mrs. R. Glenn, 6136 Reinhardt Dr., Shawnee Mission, Kan. 66205
Englemann, Mrs. Calvin E., 2000 W. 68th, Shawnee Mission, Kan. 66208
Engleman, Mrs. Reinhold, 524 W. 119th Terr. 64145
Ericsson, Mrs. Samuel E., 9800 Horton, Shawnee Mission, Kan. 66207
Eshelman, Mrs. A. D., 16705 Larkspur La., Independence 64055
Etzenhouser, Mrs. Merrill, 3318 Oxford, Apt. D, Independence 64052
Etzenhouser, Mrs. Russell F., 1317 W. College, Independence 64052
Eubank, Mrs. Dillard M., 6020 Elm 64133
Eubank, Mrs. Will R., 6113 Lane 64133
Evans, Mrs. Lawrence L., 1240 W. 69th Terr. 64113
Fairchild, Mrs. Robert C., 8425 Reinhardt La., Leawood, Kan. 66206
Farley, Mrs. Claude C., 3312 W. 87th, Leawood, Kan. 66206
Farney, Mrs. Jacob P., 2712 W. 69th, Shawnee Mission, Kan. 66208
Farnsworth, Mrs. Jesse J., 5608 Fairway, Shawnee Mission, Kan, 66205
Farrales, Mrs. Franklin, 5668 Skyline Dr., Shawnee Mission, Kan. 66205
Feist, Mrs. William E., 10618 W. 98th Terr., Shawnee Mission, Kan. 66214
Ferris, Mrs. Carl, 333 W. Meyer Blvd. 64112
Fitzgerald, Mrs. Robert H., 8505 Cherokee Pl., Shawnee Mission, Kan. 66206
Flanders, Mrs. Horace F., 5161 W. 75th, Shawnee Mission, Kan. 66208
Flately, Mrs. John A., 827 Huntington Rd. 64113
Folck, Mrs. William P., 5804 N.W. 72nd 64151
Forman, Mrs. Louis H., 2801 W. 67th, Shawnee Mission, Kan. 66208
Forsythe, Mrs. Robert W., 6457 Verona Rd., Shawnee Mission, Kan. 66208
Fouts, Mrs. Dallas, Sr., Box 124, Lee's Summit 64063
Fowler, Mrs. Fred D., 1231 W. 56th 64113
Fowler, Mrs. James, 200 W. 53rd Terr. 64112
Fredeen, Mrs. Robert C., 5437 Canterbury Rd., Shawnee Mission, Kan. 66205
Frick, Mrs. J. Paul, 116 Huntington Rd. 64113
Friedman, Mrs. Morris L., 2516 W. 69th, Shawnee Mission, Kan. 66208
Fritzlen, Mrs. Thomas J., 825 W. 63rd 64113
Gainey, Mrs. Harold L., 4907 Sunset Dr. 64112
Ganley, Mrs. William Coyle, 9927 Walnut Dr., Apt. 103 64114
Garner, Mrs. James H., 8000 Sagamore Rd., Shawnee Mission, Kan. 66206
Garrison, Mrs. Roy F., 404 W. 67th Terr. 64113
Gauthier, Mrs. Charles P., 11319 Summit 64114
Geha, Mrs. Braham J., 4 Wycklow, Shawnee Mission, Kan. 66207
Geiger, Mrs. W. A., Jr., 3506 W. 92nd Terr., Leawood, Kan. 66206
Gerdes, Mrs. Joseph, 1605 N.E. Redbud La. 64116
Gibson, Mrs. David M., 5318 Sunset Dr. 64112
Gilgore, Mrs, Alfred, 8935 Rosewood Dr., Shawnee Mission, Kan. 66207
Gillmor, Mrs. C. Stewart, 420 E, Armour 64109
Ginsberg, Mrs. Norman A., 1220 W. 67th 64113
Gist, Mrs. W. W., 1230 W. 66th 64113
Givler, Mrs. Robert L., 408 Hargis La., Belton 64012
Glasscock, Mrs. Ernest L., 6214 High Dr., Shawnee Mission, Kan. 66208
Goerz, Mrs. Royal D., 4336 Dover, Independence 64055
Goldman, Mrs. Stanley, 5734 Windsor Dr., Shawnee Mission, Kan. 66205
Goldsich, Mrs. Edward, 5115 W, 81st, Shawnee Mission, Kan. 66208
Goldstein, Mrs. Marvin F., 901 W. 113th Terr. 64114
Goodson, Mrs. W. H., 815 W. 59th 64113
Goolsbee, Mrs. Robert, 6438 Sagamore, Shawnee Mission, Kan. 66208
Gordon, Mrs. Morris P., 10527 Walnut Dr. 64114
Gottsch, Mrs. Joseph C., 7904 Granada, Prairie Village, Kan. 66208
Green, Mrs. John R., Jr., 3143 Santa Fe Terr., Independence 64055
Griffith, Mrs. John A., Jr., 6500 Granada Dr., Shawnee Mission, Kan. 66208
Grossman, Mrs. Joel, 600 W. 50th 64112
Growdon, Mrs. John A., 6508 Aberdeen Rd., Shawnee Mission, Kan. 66208
Guastello, Mrs. Mario J., 7020 Overhill Rd. Shawnee Mission, Kan. 66208
Habib, Mrs. Henry N., 440 E. 74th Terr. 64131
Hagar, Mrs. David L., 8800 E. 62nd, Raytown 64133
Hahn, Mrs. Fred, 12001 E. 48th Terr. 64133
Haight, Mrs. John M., 5609 Blue Ridge Blvd. 64133
Hall, Mrs. Ralph R., 3900 W. 57th, Shawnee Mission, Kan. 66205
Halperin, Mrs. Phillip H., 6715 W. 52nd Pl., Mission, Kan. 66222
Hamill, Mrs. Robert W., 7311 Eby Dr., Shawnee Mission, Kan. 66204
Hamlin, Mrs. Howard, 4017 W. 100th Pl., Shawnee Mission, Kan. 66207
Hamtil, Mrs. L. W., 9622 Sagamore, Shawnee Mission, Kan. 66206
Harrin, Mrs. William R., 5800 High Dr., Shawnee Mission, Kan. 66208
Hartwig, Mrs. Fred H., 5204 Pawnee Dr., Shawnee Mission, Kan. 66205
Hartwig, Mrs. Raymond W., 6546 Wenonga Rd., Shawnee Mission, Kan. 66208
Hausheer. Mrs. Herman, 12900 E. 36th Terr., Independence 64050
Haynes, Mrs. Solon E., 5306 Holmes 64110
Hellman, Mrs. Richard, 4817 W. 81st, Shawnee Mission, Kan, 66208
Helman, Mrs. Richard G., 6540 Wenonga Rd., Shawnee Mission, Kan. 66208
Herdoiza, Mrs. Alfonso W., 7015 W. 66th Terr., Shawnee Mission, Kan. 66202
Herman, Mrs. Edwin, 8 W. Bridlespur 64114
Hervey, Mrs. William H., 11, 6601 Overhill Rd., Shawnee Mission, Kan. 66208
Hibbard, Mrs. Blaine Z., 2900 W, 53rd, Shawnee Mission. Kan. 66205
Hickerson, Mrs. William H., 4207 S. Crysler, Independence 64050
Hill, Mrs. J. H., 8115 Meadow La., Leawood, Kan. 66206
Hink, Mrs. Fred W., 524 Hardy, Independence 64053
Hoadley, Mrs. William D., 9625 Beverly, Shawnee Mission, Kan. 66207
Hodgson, Mrs. Frank H., 1049 W. 55th 64113
Hoeper, Mrs. Samuel D., Box 169, Grandview 64030
Hoffman, Mrs. Alan L., 12301 W. 57th 64133
Hollinger, Mrs. Lloyd A., 4403 W. 93rd Terr., Shawnee Mission, Kan. 66207
Holman, Mrs. Joseph. 5208 Bekkeview 64112
Hollweg, Mrs. Kenneth C., 808 W .Meyer Blvd. 64113
Holton, Mrs. Edward B., 2817 Westport Rd., Independence 64052
Huet, Mrs. Raul, 8632 Juniper La., Shawnee Mission, Kan. 66207
Hughes, Mrs. Michael, 9933 Catalina, Shawnee Mission, Kan. 66207
Hunkeler, Mrs. John D., 5421 Fairway Rd., Shawnee Mission, Kan. 66205
Hunt, Mrs. Claude J., 615 W. 56th 64113
Hunt, Mrs. Thomas R., 6336 Ensley La., Shawnee Mission, Kan. 66208
Hunter, Mrs. Martin P., 4100 W. 93rd, Shawnee Mission, Kan. 66207
Hunzicker, Mrs. Warren, 1248 Stratford Rd. 64113
Huse, Mrs. William J., II, 8713 Burch La., Shawnee Mission, Kan. 66207
Hyde, Mrs. Lawrence L., 5020 W. 67th, Shawnee Mission, Kan. 66208
Ingham, Mrs. Walton C., 9723 Overbrook Rd., Leawood, Kan. 66206
Irvine, Mrs. John, 2500 Red Bridge Terr. 64131
Irwig, Mrs. Fred, 5109 87th, Shawnee Mission, Kan. 66207

Jacoh, Mrs. Walter P., 5301 W. 83rd Terr., Shawnee Mission, Kan. 66207
Jacobs, Mrs. Morton, 6416 Verona Rd., Prairie Village, Kan. 66208
Jacohs, Mrs. Walter H., 6656 Milhaven Dr., Shawnee Mission, Kan. 66202
James, Mrs. Otis E., Jr., 2810 W. 68th, Shawnee Mission, Kan. 66208
Jenab, Mrs. Morteza, 5964 Overhill Rd., Shawnee Mission, Kan. 66208
Jobnson, Mrs. C. Laurence, 729 S. 53rd, Kansas City, Kan. 66106
Johnson, Mrs. Dallas A., 5321 96th Terr., Shawnee Mission, Kan. 66207
Johnson, Mrs. Joseph, 707 W. Montcrew Dr. 64114
Jonas, Mrs. Harry S., 11711 Markham Rd., Independence 64052
Jones, Mrs. Gale O., 817 W. 61st 64113
Jones, Mrs. Samuel T., 9915 Cherokee La., Shawnee Mission, Kan. 66207
Jones, Mrs. T. Reid. 6341 Roe, Shawnee Mission, Kan. 66208
Justus, Mrs. John B., 5221 Howe Dr., Shawnee Mission, Kan. 66205
Kanarek, Mrs. Josepb, 6112 W. 87th Terr., Shawnee Mission, Kan. 66207
Kandt, Mrs. Ray E., Jr., 8900 Maple Dr., Shawnee Mission, Kan. 66207
Kantor, Mrs. Julius M., 6708 High Dr., Shawnee Mission, Kan. 66208
Kantor, Mrs. Samuel, 3604 W. 87th, Leawood. Kan. 66206
Katif, Mrs. Nichola Y., 11812 Central 64114
Kaufman, Mrs. Andrew B., 4117 N. 94th Terr., Shawnee Mission, Kan. 66207
Kay, Mrs. Billy F., 10326 Sagamore La., Leawood, Kan. 66206
Kavanan, Mrs. Jose, 200 W. 100th Terr. 64114
Keairnes, Mrs. Harold W., 5323 Oak 64112
Keeler, Mrs. James E., 425 E. Meyer Blvd. 64131
Keeling. Mrs. Douglas, 7705 W. 102nd, Shawnee Mission, Kan. 66212
Keltner. Mrs. Raymond O.. 8900 Pawnee La., Leawood, Kan. 66206
Kendall, Mrs. Charles A., 604 Red Rd., Independence 64055
Kendall. Mrs. Forrest H., 2505 W. 71st, Prairie Village, Kan. 66208
Kendall, Mrs. Malcolm, 10271 Rosewood, Shawnee Mission, Kan. 66207
Kennard. Mrs. G. Keith, 3658 Madison 64111
Kent. Mrs. Bela, 5839 Cherokee, Shawnee Mission. Kan. 66205
Kettner. Mrs. Edward G., 6510 Milhaven Dr., Shawnee Mission, Kan. 66202
Kiene, Mrs. Richard H., 6429 Overbrook Rd., Shawnee Mission, Kan. 66208
Killen. Mrs. Duncan A., 1909 W. 70th, Shawnee Mission, Kan. 66208
Kindred. Mrs. Lynn H., 4606 W. 82nd Terr., Prairie Village, Kan. 66208
Kitchen. Mrs. W. M.. 2700 W. 68th, Shawnee Mission. Kan. 66208
Klein, Mrs. E. H., 7011 Roe, Prairie Village, Kan. 66208
Knoch. Mrs. H. Kermit, 6606 Willow La., Shawnee Mission. Kan. 66208
Koontz, Mrs. Paul G., 809 W. 57th 64113
Koppers, Mrs. Lawrence E., 500 E. Woodbridge La. 64137
Kranson, Mrs. Seymour I.. 11 Hawthorne Pl., Independence 64052
Kurtz, Mrs. Karl J., 10012 Wedd Dr., Shawnee Mission, Kan. 66212
Kuruvilla, Mrs. George, 11201 Jefferson 64114
Kyger, Mrs. Jobn E., 3612 Blue Ridge, Independence 64052
Lamar. Mrs. Rohert F., 800 W. 53rd Terr. 64112
Lamhie, Mrs. Rodger W., 10317 Grant La., Shawnee Mission, Kan. 66212
Landers, Mrs. Burnell, 13101 Delaware Dr., Independence 64055
Landis, Mrs. George K., 10115 Pawnee La., Shawnee Mission, Kan. 66206
Latham, Mrs. Raymond W., 3008 W. 67th, Shawnee Mission, Kan. 66208
Layle, Mrs. John K., 5500 Chadwick, Shawnee Mission, Kan. 66205
Layton. Mrs. Ira, 10004 Walnut Dr. 64114
Lee, Mrs. Gerald B., 13412 E. 51st 64133
Lee, Mrs. Henry A., 9821 Sagamore Rd., Leawood, Kan. 66206
Lee, Mrs. King Y., 10811 W. 100th St. Terr. Shawnee Mission, Kan. 66214
Lemoine, Mrs. Albert N., Sr., 9200 High Dr., Leawood. Kan. 66206
Lentz, Mrs. Clark H., 2600 W. 69th, Shawnee Mission, Kan. 66208
Leo, Mrs. William A., 4505 W. 66th, Prairie Village, Kan. 66208
Lindgren, Mrs. Cbarleton J., 12805 E. 38th, Independence 64055
Link, Mrs. Vance E., 1201 W. 36th, Independence 64050
Linville, Mrs. Howard E., 9905 Cherokee La., Leawood, Kan. 66206
Long, Mrs. R. Stacy, 3343 Blue Ridge Blvd., Independence 64052
Lotito, Mrs. Carlos, 2603 W. 70th Terr., Shawnee Mission, Kan. 66208
Loutzenhizer, Mrs. James K., 11405 Jefferson 64114
Lowell, Mrs. Paul, 4742 Liberty 64112
Lundgren, Mrs. Fred H., Jr., 201 W. 116th 64114
Lulo, Mrs. Antonio, 8726 Cherokee La., Leawood, Kan. 66206
Lyddon, Mrs. H. R., Jr., 1221 W. 67th 64113
Lytton, Mrs. George J., 617 W. 49th 64112
Mahen, Mrs. Sam E., 8954 E. 60th Terr. 64133
MacGee, Mrs. Edwin E., 10012 Hardy Dr., Shawnee Mission, Kan. 66214
MacNaugbton, Mrs. Ralph E., 17 Wycklow, Overland Park, Kan. 66207
MacNaughton, Mrs. Rohert, 3208 W. 101st, Shawnee Mission, Kan. 66206
Mallouck, Mrs. Alexander G., 6508 W. 102nd, Shawnee Mission, Kan. 66212
Mangels, Mrs. Kenneth A.. Jr., 1103 W. 36th Terr., Independence 64055
Mantz, Mrs. Herbert L., 1209 Romany Rd. 64113
Marks, Mrs. Mark M., 6537 Summit 64113
Martin, Mrs. Clyde V., 5531 W. Mission Dr., Shawnee Mission, Kan. 66208
Masucci, Mrs. Joseph M., 11800 Washington 64114
Mathews, Mrs. Robert, 9244 Riggs La., Shawnee Mission, Kan. 66212
Mayer, Mrs. John H., Jr., 5739 Windsor Dr., Shawnee Mission, Kan. 66205
McCallister, Mrs. Ben D., 6431 Norwood, Shawnee Mission, Kan. 66212
McCanse, Mrs. Andrew, 1232 W. 60th Terr. 64113
McClanahan, Mrs. Rohert C., 6456 Overhrook Rd., Shawnee Mission, Kan. 66208
McConahay, Mrs. David R., 3002 W. 67th Terr., Shawnee Mission, Kan. 66207
McCoy, Mrs. Frederick J., 5814 Mission Dr., Shawnee Mission, Kan. 66208
McDonald, Mrs. Herbert L., 435 W. 58th 64113
McDonnell, Mrs. John F., 5411 Central 64112
McGannon, Mrs. Paul, 2201 Arno Rd., Shawnee Mission, Kan. 66208
McIntosb, Mrs. Donald E., 12709 Oakmont Dr. 64145
McKee, Mrs. Wallace P., 2020 Stratford Rd., Shawnee Mission, Kan. 66208
McKnelly, Mrs. William V., 7228 Hadley, Shawnee Mission, Kan. 66204
McMillan, Mrs. Thomas E., 8201 Dearborn, Shawnee Mission, Kan. 66208
McNabney, Mrs. W. Kendall, 5319 Oak 64112
Medicott, Mrs. William, 1209 W. 67th 64113
Meegan, Mrs. Robert J., 401 W. 119th Terr. 64145
Mehta, Mrs. Satish K., 2307 E. 109th 64131
Melgaard, Mrs. S. Ross, 1012 W. 61st Terr. 64113
Meyer, Mrs. Paul W., 5160 Sunset Dr. 64112
Meyers, Mrs. Harold L., 1901 Brookwood Rd., Shawnee Mission, Kan. 66208
Miles, Mrs. George O., 9020 Mission Rd., Shawnee Mission, Kan. 66206
Milgram, Mrs. Byron A., 1209 W. 66th Terr. 64113
Miller, Mrs. Gerald L., 836 W. 51st 64112
Miller, Mrs. Max I., 4001 W. 66th, Prairie Village, Kan. 66208
Miller, Mrs. Wilson H., 6400 Verona Rd., Shawnee Mission, Kan. 66208
Mitchell, Mrs. Andrew D., 4013 W. 73rd Terr., Shawnee Mission, Kan. 66208
Mitchell, Mrs. John D., 6104 Lockton La., Shawnee Mission, Kan. 66205
Mitra, Mrs. Nirmal, 2007 W. 81st Terr., Leawood, Kan. 66206
Mixson, Mrs. William C., 6501 Sagamore Rd., Shawnee Mission, Kan. 66208
Montello, Mrs. Samuel A., 4109 Delmar Dr., Prairie Village, Kan. 66208
Mooney, Mrs. Marcel L., 6439 Ensley La., Prairie Village, Kan. 66208
Moore, Mrs. Rohert A., 10818 W. 102nd, Shawnee Mission, Kan. 66214
Moreano, Mrs. Armando H., 8417 Nall, Shawnee Mission, Kan. 66207
Morgan, Mrs. David B., 6513 Jefferson 64113
Morris, Mrs. Joseph H., 5015 George 64133
Morrison, Mrs. J. Scott, 8932 Rosewood, Prairie Village, Kan. 66207
Morrow, Mrs. Raymond L., 17 W. 69th 64113
Moshacher, Mrs. Hugh E., 16509 E. 32nd, Independence 64055
Mosser, Mrs. Robert S., 8342 Carter, Overland Park, Kan. 66212
Mueller, Mrs. M. J., 11723 Central 64114
Mullen, Mrs. Leo M., 1900 W. 68th, Shawnee Mission, Kan. 66208
Murpby, Mrs. Robert J., 6428 High Dr., Shawnee Mission, Kan. 66208
Murray, Mrs. W. Lee, 16 Wycklow, Overland Park, Kan. 66207
Naime, Mrs. Mansour J., 9625 Linden Dr., Shawnee Mission, Kan. 66207
Negrete, Mrs. Ahelardo, 6932 Marty, Overland Park, Kan. 66204
Nesselrode, Mrs. Jobn H., 12000 Marbec Trail, Independence 64052
Neumann, Mrs. James, 5850 Pemhroke Ct., Shawnee Mission, Kan. 66208
Nickson, Mrs. Charles E., Jr., 4425 Larson 64133
Nohack, Mrs. R. K., 628 W. 67th 64113
Noltensmeyer, Mrs. Milton, 3305 W. 50th Terr., Shawnee Mission, Kan. 66205
O'Farrell, Mrs. Thomas, 2000 Stratford Rd., Shawnee Mission, Kan. 66208
O'Hearne, Mrs. John J., 121 W. 48th 64112
Osborne, Mrs. Jere, 644 W. 69th Terr. 64113
Overesch, Mrs. Harry B., 10804 Grandview Rd. 64137
Ozar, Mrs. Milton B., 1206 W. 62nd 64113
Padfield, Mrs. Earl G., 1900 W. 61st Terr., Shawnee Mission, Kan. 66208
Pakula, Mrs. Sidney F., 10839 State Line 64114
Pallett, Mrs. Harold, 5000 Oak, Apt. 312 64112
Parker, Mrs. Hubert M., 1200 W. Red Bridge Rd. 64114
Pelegrin, Mrs. Robert, 32 E. Concord 64112
Pemherton, Mrs. L. Beaty, 9921 W. 65th Dr., Shawnee Mission, Kan. 66203
Penner, Mrs. Stanley, 4302 W. 93rd Terr., Shawnee Mission, Kan. 66207
Perico, Mrs. Carkos, 8729 Rosewood, Shawnee Mission, Kan. 66207
Perll, Mrs. Maurice F., 830 W. 61st Terr. 64113
Perry, Mrs. Ralpb, 7140 Sni-A-Bar Rd. 64129
Peterson, Mrs. Eugene G., 108 Hackherry, Lee's Summit 64063
Peterson, Mrs. George, 4806 W. 68th, Shawnee Mission, Kan. 66208
Pfeutz, Mrs. Edwin L., 5407 W. 100th Terr., Shawnee Mission, Kan. 66207
Pickering, Mrs. Lee, 5920 McGee 64113
Piper, Mrs. Donald K., 9929 High Dr., Shawnee Mission, Kan. 66206
Piepergerdes, Mrs. Larry G., 1410 W. 5th, Lee's Summit 64063
Pinkerton, Mrs. Josepb A., Jr., 2019 W. 70th Terr., Shawnee Mission, Kan. 66208
Pollock, Mrs. Leo H., 6610 Wenonga Terr., Shawnee Mission, Kan. 66208
Poonawala, Mrs. Huseni E., 901 E. 109th Terr. 64131
Porter, Mrs. Louis, 6017 McGee 64113
Porter, Mrs. Micbael, 6925 Belinder, Shawnee Mission, Kan. 66208
Pugh, Mrs. Richard G., 102 Golfview Dr., Blue Springs 64015
Quer, Mrs. Erich A., 1901 Stratford Rd., Shawnee Mission, Kan. 66208
Raicb, Mrs. Robert A., 828 Greenway Terr. 64113
Ramey. Mrs. Ehret O., 8108 Ward Parkway Plaza 64114
Rector, Mrs. Joe Lee, Jr., 3915 W. 53rd, Shawnee Mission, Kan. 66205
Reed, Mrs. William A., 5931 High Dr., Shawnee Mission, Kan. 66208
Reinhardt, Mrs. G. Robert, 1201 Romany Rd. 64113
Riller, Mrs. L. E., 1267 W. 61st 64113
Robinson, Mrs. Arthur W., 6600 Wenonga Rd., Shawnee Mission, Kan. 66208
Robinson, Mrs. James Travis, Jr., 4203 W. 92nd Terr., Shawnee Mission, Kan. 66207

Robinson, Mrs. William J., 9931 Lee Circle, Shawnee Mission, Kan. 66206
Robles, Mrs. Luis H., 5219 Farley La., Shawnee Mission, Kan. 66203
Rodgers, Mrs. George H., 10041 El Monte La., Shawnee Mission, Kan. 66207
Rofail, Mrs. Amin, 9206 England, Shawnee Mission, Kan. 66212
Romito, Mrs. Anthony J., 9015 Lamar, Shawnee Mission, Kan. 66207
Rubin, Mrs. Harvey P., 4606 W. 87th Terr., Shawnee Mission, Kan. 66207
Rubin, Mrs. Sidney, 1287 W. 72nd 64114
Rubnitz, Mrs. Leon H., 210 W. 94th 64114
Russell, Mrs. James L., 815 W. 55th 64113
Sabates, Mrs. Felix, 2503 W. 70th Terr., Shawnee Mission, Kan. 66208
Saferstein, Mrs. A. Lester, 6859 Cherry 64131
Sanders, Mrs. Donald, 11721 Oak 64114
Sanders, Mrs. William F., 1004 W. 66th Terr. 64113
Sauer, Mrs. Gordon C., 830 W. 58th Terr. 64113
Schaerrer, Mrs. W. W., 5245 Mercier 64112
Schiffmacher, Mrs. Jack E., 4517 W. 65th, Prairie Village, Kan. 66208
Schillie, Mrs. Gene A., 8232 Linden, Shawnee Mission, Kan. 66208
Schlozman, Mrs. Daniel L., 9315 Lamar, Shawnee Mission, Kan. 66207
Schoolman, Mrs. Arnold, 8705 Catalina Dr., Shawnee Mission, Kan. 66207
Schottman, Mrs. Gerhard W., Jr., 5110 W. 96th Terr., Shawnee Mission, Kan. 66207
Seeley, Mrs. Clark W., 3000 W. 68th, Shawnee Mission, Kan. 66208
Seiden, Mrs. Gerald D., 2509 W. 71st, Prairie Village, Kan. 66208
Sells, Mrs. Kenneth J., 2929 Baltimore, Suite 310, 64108
Shalley, Mrs. Jack E., 14401 E. 44th, Independence 64055
Shapiro, Mrs. L. M., 6429 Holmes 64131
Sheahon, Mrs. John, 7037 Lakeshore Dr., Raytown 64133
Sheldon, Mrs. Russell D., 816 W. 58th Terr. 64113
Shifrin, Mrs. Alexander, 1027 W. 69th Terr. 64113
Shireman, Mrs. Kenneth L., Noland Rd. & 55th Terr., Rt. 3 64133
Shuey, Mrs. Herbert H., 5339 W. 96th, Shawnee Mission, Kan. 66207
Simon, Mrs. Sanford, 5820 Mission Dr., Shawnee Mission, Kan. 66208
Sinclair, Mrs. Alexander B., Jr., 1230 W. 61st Terr. 64113
Sinclair, Mrs. Richard H., 3908 W. 91st, Shawnee Mission, Kan. 66207
Singleton, Mrs. Charles M., II, 6518 Maple Dr., Shawnee Mission, Kan. 66202
Singleton, Mrs. John, III, 9030 High Dr., Shawnee Mission, Kan. 66206
Skillman, Mrs. Robert K., 10335 High Dr., Shawnee Mission, Kan. 66206
Skinner. Mrs. John T., 824 Westover Rd. 64113
Slentz, Mrs. Edwin L., 4812 W. 66th Terr., Shawnee Mission, Kan. 66208
Slentz, Mrs. William A., 9835 Pembroke La., Shawnee Mission, Kan. 66206
Slickman, Mrs. Robert A., 4937 Wyoming 64112
Smith, Mrs. Arthur B., 8409 Wenonga Rd., Shawnee Mission, Kan. 66206
Smith, Mrs. Othello D., 5400 W. 83rd, Shawnee Mission, 66206
Smith, Mrs. Wallace B., 3611 S. Delaware, Independence 64050
Sneid, Mrs. Philip, 4201 W. 90th Terr., Shawnee Mission, Kan. 66207
Snider, Mrs. Wilbur Ray, 1321 W. 50th Terr. 64112
Spafford, Mrs. Allen L., 5552 Belinder Ave., Shawnee Mission, Kan. 66206
Spalding, Mrs. Wilbur B., Jr., 6206 Robinson, Shawnee Mission, Kan. 66202
Spurny, Mrs. Otto M., 6400 Cherry 64131
Stacey, Mr . Wallace R., 3407 Shady Bend Dr., Independence 64052
Staggs, Mrs. William A., 641 E. 45th 64110
Staley, Mrs. Harry R., 4740 Roanoke Pkwy. 64112
Stanley, Mrs. John H., 5307 W. 100th, Shawnee Mission, Kan. 66207
Statland, Mrs. Harry, 1016 W. 69th Terr. 64113
Statland, Mrs. Morris, 2911 W. 66th Terr., Shawnee Mission, Kan. 66208
Steffen, Mrs. L. F., 9548 Rosewood La., Shawnee Mission, Kan. 66207
Stelmach, Mrs. W. Jack, 4303 W. 93rd Terr. Shawnee Mission, Kan. 66207
Stephens, Mrs. Jack D., 10 Oak Hill Cluster, Independence 64057
Stern, Mrs. Thomas L., 1235 W. 62nd 64113
Stockton, Mrs. Raymond W., 5215 W. 81st, Prairie Village, Kan. 66208
Stribling, Mrs. Thomas L., 3808 S. Union, Independence 64055
Stuber, Mrs. Jack L., 5617 Pembroke La., Shawnee Mission, Kan. 66208
Sulit, Mrs. Arnulfo B., 11001 W. 100th Pl., Shawnee Mission, Kan. 66214
Sutton, Mrs. Richard L., Jr., 3203 W. 83rd Terr., Leawood, Kan. 66206
Szabados, Mrs. Ernest D., 1901 S. Leslie, Independence 64050
Thalblum, Mrs. Harvey, 8405 Ensley La., Shawnee Mission, Kan. 66206
Thomas, Mrs. Christopher Y., Jr., 5830 Mission Dr., Shawnee Mission, Kan. 66208
Thompson, Mrs. C. Leslie, 1256 W. 61st Terr. 64113
Throne, Mrs. Benjamin, 7919 Sagamore Rd., Shawnee Mission, Kan. 66208
Throne, Mrs. Elias M., 10621 W. 102nd, Overland Park, Kan. 66214
Tice, Mrs. Wayne K., 3504 S. Delaware, Independence 64050
Tillema, Mrs. David A., 8015 El Monte, Shawnee Mission, Kan. 66208
Toubes, Mrs. Daniel, 9718 Menonga, Leawood, Kan. 66206
Troeh, Mrs. Richard, 13000 Delaware Dr., Independence 64055
Trowbridge, Mrs. E. H., Jr., 32 Compton Ct., Shawnee Mission, Kan. 66208
Turano, Mrs. William, 7000 Lake Shore Dr., Raytown 64133
Tutera, Mrs. D. F., 1260 W. 63rd Terr. 64113
Twin, Mrs. Edward, 8208 Tomahawk, Shawnee Mission, Kan. 66208
Twyman, Mrs. Richard A., 1020 W. 56th 64113
Underwood, Mrs. Dick H., 9828 Belinder, Shawnee Mission, Kan. 66206
Van Biber, Mrs. James T., 3705 Northern Blvd., Independence 64052
Vaughn, Mrs. James W., 5509 W. 86th, Shawnee Mission, Kan. 66207
Vera, Mrs. Enrique, 9218 W. 82nd Terr., Shawnee Mission, Kan. 66204
Victor, Mrs. Frank, 9639 Chadwick, Shawnee Mission, Kan. 66206
Vidals, Mrs. V. G., 9509 W. 104th Terr., Overland Park, Kan. 66212
Vincent, Mrs. Jack C., 2003 W. 67th Terr., Shawnee Mission, Kan. 66208
Virden, Mrs. Herbert H., 6533 High Dr., Shawnee Mission, Kan. 66208
Vogel, Mrs. Arthur P., 6524 Willow La., Shawnee Mission, Kan. 66208
Volk, Mrs. George E., 109 W. 115th 64114
Vothe, Mrs. Harold W., 5413 Neosho, Shawnee Mission, Kan. 66205
Wade, Mrs. Frederick E., 413 W. 62nd 64113
Wagner, Mrs. Paul J., Greenwillow Farm, Rt. 1, Greenwood 64034
Walker, Mrs. John W., 10336 Mohawk, Shawnee Mission, Kan. 66206
Walker, Mrs. Orville C., Jr., 604 Partridge, Independence 64050
Wall, Mrs. Leonard A., 5011 Neosho Ave., Shawnee Mission, Kan. 66205
Waxman, Mrs. Herbert, 2012 W. 81st, Shawnee Mission, 66206
Weidmaier, Mrs. E. John. 9728 N. Charlotte 64155
Weir, Mrs. Robert K., 10015 E. 36th, Independence 64052
Wells, Mrs. Donald E., 1-18 Lake Lotowana, Rt. 4, Lee's Summit 64063
Wheeler, Mrs. Charles B., 830 W. 53rd 64112
Wheeler, Mrs. John H., 5650 Mission Dr., Shawnee Mission, Kan. 66208
White, Mrs. Charles H., 6518 Overhill Rd., Prairie Village, Kan. 66208
White, Mrs. Stroughton F., 6815 Cherokee La., Shawnee Mission, Kan. 66208
Whiteman, Mrs. John R., 9729 Cherokee La., Leawood, Kan. 66206
Whitman, Mrs. Doyle C., 6836 Cherokee La., Shawnee Mission, Kan. 66208
Whitmore, Mrs. J. Stewart, 1039 W. 58th 64113
Whitten, Mrs. John S., 3823 Trail Ridge, Independence 64055
Wicks, Mrs. Edwin D., 506 N.W. 43rd Terr. 64116
Wilber, Mrs. Robert D., 6056 Mission Dr., Shawnee Mission, Kan. 66208
Wilhelm, Mrs. Warren F., 3100 W. 67th, Shawnee Mission, Kan. 66208
Wilkinson. Mrs. E. A., 6810 Linden La., Prairie Village, Kan. 66208
Williams, Mrs. Frank, 5921 Ward Parkway 64113
Williams, Mrs. George P., 9413 Ralston 64138
Williams, Mrs. Joseph C., Jr., 2209 Arno Rd., Shawnee Mission, Kan. 66202
Williams, Mrs. Vincent T., 4400 Blue Ridge Blvd. 64133
Willoughby, Mrs. James W., 420 N. Ridge, Liberty 64068
Willoughby, Mrs. Jean B., 1019 W. 69th Terr. 64113
Wilson, Mrs. Clifford C., 5531 Neosho La., Shawnee Mission, Kan. 66205
Winer, Mrs. Herbert J., 2103 W. 69th Terr., Shawnee Mission, Kan. 66208
Winer, Mrs. Nathaniel, 1007 Brentwood Circle 64112
Winston, Mrs. Bernard H., 1006 W. 67th 64113
Wise, Mrs. Morris F., 2610 W. 105th, Leawood, Kan. 66206
Wolf, Mrs. Jack, 6125 Morningside Dr. 64113
Woods, Mrs. S. Dwight, 3201 W. 68th, Shawnee Mission, Kan. 66208
Woods, Mrs. Walton C., 9004 E. 73rd 64133
Wortmann, Mrs. Robert F., 2819 W. 66th Terr., Shawnee Mission, Kan. 66208
Wright, Mrs. R. Paul, 9119 Riggs La., Shawnee Mission, Kan. 66212
Wu, Mrs. William, 6700 Troost 64131
Wurster, Mrs. Jerry B., 5218 W. 98th Terr., Shawnee Mission, Kan. 66207
Youll, Mrs. Donald V., 8711 Ensley La., Shawnee Mission, Kan. 66206
Youmans, Mrs. Ronald, 3901 W. 73rd, Shawnee Mission, Kan. 66208
Young, Mrs. James E., 9700 Overbrook Rd., Leawood, Kan. 66206
Young, Mrs. J. W., 5443 Mohawk, Shawnee Mission, Kan. 66205
Zacharias, Mrs. David L., 7819 N.W. Westside Dr. 64152
Zahony, Mrs. Ivan, 8720 Rosewood, Shawnee Mission, Kan. 66207
Zoglin, Mrs. Nathan, 333 W. Meyer Blvd. 64113
Zoller, Mrs. David D., 74 Lake Shore Dr. West, Kansas City, Kan. 66106
Zwerenz, Mrs. Bruno, 15 A Lake Tapawingo, Blue Springs 64015

JASPER COUNTY
(Joplin)

Adams, Mrs. Robert, 1302 Mississippi 64801
Allen, Mrs. David O., Rt. 4, Box 85 64801
Alquist, Mrs. Dale, 21st & Fairview, Baxter Springs, Kan. 66713
Bentlage, Mrs. Charles, 1302 Fairmont Dr. 64801
Bhend, Mrs. David, 2435 E. 12th 64801
Bird, Mrs. William F., Rt. 2, Box 144, Lot 17 64801
Black, Mrs. M. H., 2814 Wisconsin 64801
Bladow, Mrs. Terrence, 2703 Mississippi 64801
Bopp, Mrs. Ronald, 505 Glenview 64801
Brandon, Mrs. Frederick, 2609 E. 12th 64801
Burch, Mrs. John E., 1345 Crest Dr. 64801
Burleigh, Mrs. Bruce, 601 Jaccard Pl. 64801
Butler, Mrs. Patrick, Rt. 1, Box 280, Diamond 64840
Carnes, Mrs. Victor, 1418 Crestwood Dr. 64801
Chase, Mrs. Ned, 2931 Indiana 64801
Chesney. Mrs. George W., Jr., 2416 E. 12th 64801
Cohle. Mrs. Richard, 1609 Lilac La., Carthage 64836
Craig, Mrs. Irwin T., 2525 E. 12th 64801
Crawford, 2931 Pearl Ave. 64801
Crispell. Mrs. Lawrence, 911 Kensington Rd. 64801
Curl, Mrs. Howard, 2031½ Pearl 64801
Detar, Mrs. Burleigh, Sr., 410 Jackson 64801
Dixon, Mrs. Herbert, Rt. 2, Box 221 64801
Esther, Mrs. John, 612 Glenview 64801
Ferguson, Mrs. Ralph, 420 E. 33rd 64801
Ferguson, Mrs. Robert M., 2319 E. 10th 64801
Fritsch, Mrs. Andrew, 2920 Pearl 64801
Gardner, Mrs. Joe, 1002 N. Moffet 64801
Gaston, Mrs. Samuel, 2720 Ohio 64801
George, Mrs. Bill, 403 E. 14th, Carthage 64836
Grim, Mrs. Edward, 1402 Mississippi 64801
Hallaba, Mrs. Moheb, Rt. 2, Box 197C 64801
Hamilton, Mrs. Eugene, 2736 E. 15th 64801

Hilton, Mrs. Paul, 1612 Murphy Blvd. 64801
Majzoub, Mrs. Hish, 2802 Illinois 64801
Isbell, Mrs. C. H., 1046 S. Garrison, Carthage 64836
Jeans, Mrs. Virgil, 660 Jaccard Pl. 64801
Kirkman, Mrs. Robert E., 2504 E. 10th 64801
Koehler, Mrs. John W., 1001 Manitou 64801
Longnecker, Mrs. J. L., 2606 E. 14th 64801
MacLaughlin, Mrs. James, 728 N. Pearl 64801
Maddox, Mrs. John, 1330 Crest Dr. 64801
Manalo, Mrs. Gil B., 1320 S. Main, Carthage 64836
Martin, Mrs. Clarence, 2419 E. 10th 64801
McGonigle, Mrs. James, 1037 Campbell Pkwy. 64801
McPike, Mrs. Lloyd H., 2217 Brownell 64801
Mueller, Mrs. Adolph, 615 Hampton Pl. 64801
Papp, Mrs. Sandor D., 3343 Pearl 64801
Patterson, Mrs. Donald R., 210 Duquesne 64801
Patterson, Mrs. Grover, 1727 River, Carthage 64836
Pence, Mrs. Wendell, Rt. 4, Box 309-D, Carthage 64836
Powell, Mrs. Robert, 1818 Galena, Galena, Kan. 66739
Pryor, Mrs. I. Joe, 2625 Wisconsin 64801
Roberts, Mrs. Howard, 650 Jaccard Pl. 64801
Schoeberl, Mrs. C. B., 3111 E. 4th 64801
Schulte, Mrs. Gregory A., 2515 E. 12th 64801
Scorse, Mrs. S. W., 619 W. 2nd 64801
Simons, Mrs. Jess, 2700 McClelland Blvd. 64801
Smith, Mrs. Roland T., 1444 Crestwood 64801
Smith, Mrs. Russell W., 315 Euclid, Carthage 64836
Straub, Mrs. David L., 811 N. Byers 64801
Upsher, Mrs. Albert E., 69 Canterbury 64801
Vineyard, Mrs. Jack, 601 S. Jackson 64801
Walker, Mrs. Paul, 1022 N. Sergeant 64801
Wieman, Mrs. Harry K., 636 N. Wall 64801
Wilcoxson, Mrs. Robert, 1330 Valle Dr. 64801
Wood, Mrs. George H., 530 E. Highland, Carthage 64836
Wooldridge, Mrs. Bart, 1435 Crestwood 64801
Young, Mrs. C. C., 2518 Markwardt 64801

JEFFERSON COUNTY

Albano, Mrs. Benjamin, 114 Mississippi Ave., Crystal City 63019
Allbee, Mrs. Roger H., 121 B Mississippi Ave., Crystal City 63019
Bai, Mrs. Zangzin, 233 Main, Festus 63208
Bonifacio, Mrs. Andres, 121 Mississippi Ave., Crystal City 63019
Deles, Mrs. Vincente D., 121 Mississippi Ave., Crystal City 63019
Donnell, Mrs. Harold E., 702 N. Main, De Soto 63020
Donnell, Mrs. Robert H., 112 Mississippi Ave., Crystal City 63019
Glasgow, Mrs. David S., 113 Mississippi Ave., Crystal City 63019
Judge, Mrs. Walter T., 125 Mississippi Ave., Crystal City 63019
Mayfield, Mrs. J. Logan, 106 Mississippi Ave., Crystal City 63019
Park, Mrs. Duk J., 106 N. Mill, Festus 63028
Sirintrapun, Mrs. Seyvee, 303 Main, Festus 63028
Verzola, Mrs. Eufenio G., Main, Herculaneum 63048

JOHNSON COUNTY
(Warrensburg 64093)

Cooper, Mrs. R. Lee, Rt. 1
Cooper, Mrs. Robert L., 310 Johnson Dr.
Damron, Mrs. O. H., 308 Jones
Folkner, Mrs. Albert L., Rt. 1
Hanna, Mrs. Hugh, Rt. 3
Hobbs, Mrs. George H., Grandview Dr., Rt. 2
Johnson, Mrs. Charles S., 502 Hurricane Hill
Jones, Mrs. Keith D., 711 S. Holden
Lederer, Mrs. Charles M., 617 Clark
Maxson, Mrs. T. Reed, Arilen Acres
Ragland, Mrs. Jerry, Rt. 4

LAFAYETTE-RAY COUNTIES

Boydston, Mrs. Wayne, Odessa 64076
Brady, Mrs. Hugh, Concordia 64020
Cook, Mrs. Thomas B., Richmond 64085
Cope, Mrs. Joseph S., Lexington 64067
Crozier, Mrs. Frank, Sr., Rt. 2, Richmond 64085
Davault, Mrs. George, Richmond 64085
Johnston, Mrs. Esther, Concordia 64020
Kelling, Mrs. Jordan, Waverly 64096
Koppenbrink, Mrs. W. E., Sr., Higginsville 64037
Koppenbrink, Mrs. W. E., Jr., Higginsville 64037
LaHue, Mrs. William, Sleepy Hollow Dr., Lexington 64067
Liston, Mrs. Odis, Oak Grove 64075
Martin, Mrs. W. E., Odessa 64076
McFadden, Mrs. Gene, Waverly 64096
Meyer, Mrs. Jerry, 302 Sunset Hill Dr., Concordia 64020
Pavlu, Mrs. Robert R., 14 W. 13th, Carrollton 64633
Riley, Mrs. Charles, Rt. 2, Richmond 64085
Vajaranant, Mrs. Manit, Rt. 1, Lexington 64067
Ward, Mrs. Joe W., 1004 Francis, Lexington 64067

MILLER-MORGAN-MONITEAU COUNTIES

Buehler, Mrs. Carl T., Eldon 65026
Burke, Mrs. J. P., California 65018
Fulks, Mrs. Richard B., California 65018
Gallagher, Mrs. Lionel M., California 65018
Gunn, Mrs. Jack, Versailles 65084
Hall, Mrs. C. Robert, 2 Country Pl., Versailles 65084
Latham, Mrs. Kenyon, 200 S. High St., California 65018
Lyle, Mrs. Ray, 209 S. Maple, Versailles 65084
Shelton, Mrs. E. D., Eldon 65026
Washburn, Mrs. J. L., Versailles 65084

PETTIS COUNTY
(Sedalia 65301)

Block, Mrs. Jerome E., Rt. 2
Boger, Mrs. John W., 2803 Skyline Dr.
Braverman, Mrs. Elliott M., Rt. 3, Walnut Hills
Brazos, Mrs. John, Rt. 2
Campbell, Mrs. Albert J., 1500 W. 16th
Cole, Mrs. William R., Rt. 1, Smithton 65350
Edwards, Mrs. David R., 1619 S. Moniteau
Edmonds, Mrs. Robert, 2413 S. Stewart
Eldenburg, Mrs. Donald, Rt. 2
Erickson, Mrs. H. John, Rt. 3, Walnut Hills
Farkas, Mrs. Robert, Rt. 3
Fisher, Mrs. Stanley D., 2200 S. Kentucky
Glass, Mrs. Robert, 701 W. Broadway
Hopkins, Mrs. Thomas J., 1506 W. Broadway
Hopkins, Mrs. T. S., 524 S. Grand Ave.
Lamy, Mrs. John E., 400½ Dal-Whi-Mo Ct.
Long, Mrs. Frank B., 723 W. 7th
Owens, Mrs. John H., 3003 Wing
Proctor, Mrs. Donald, 610 W. Third
Roberts, Mrs. Paul A., 101 E. Marshall, Sweet Springs 65351
Stauffacher, Mrs. Gordon C., 1313 W. Broadway
Stockwood, Mrs. Robert C., Rt. 3
Stewart, Mrs. Robert H., 201 Driftwood Dr.
Walter, Mrs. A. L., 1000 W. 7th

ST. CHARLES-LINCOLN COUNTIES
(St. Charles 63301)

Altman, Mrs. Martin P., 10467 Corbeil Dr., Creve Coeur 63141
Baird, Mrs. Keim L., 16 Warrwick Ct.
Cabrera, Mrs. Tom, 10 Marquette, O'Fallon 63366
Canty, Mrs. Eugene, 1825 Sibley
Carpenter, Mrs. James, Rt. 5, Box 42, O'Fallon 63366
Clay, Mrs. Calvin, 808 Oak
Commerford, Mrs. John, 10 Rio Vista
Connelly, Mrs. Michael, 18 Huntleigh Downs, Frontenac 63131
Crider, Mrs. Russell, 1875 S. River Rd.
Damron, Mrs. Edward, 602 N. 5th, Elsberry 63343
Del Pizzo, Mrs. Ferdinand, 900 Westminster Dr.
Di Flippo, Mrs. Emil, 14825 Woodford Way, Bridgeton 63044
Duncan, Mrs. David, 12911 Cedarledge Ct., Creve Coeur 63141
Fleming, Mrs. Robert, 2 Indian Hills Ct.
Goldkamp, Mrs. John, 10 Shawnee
Hammes, Mrs. Roman, 505 Concordia
Hanlon, Mrs. Russell, 2616 Brookridge La.
Hetlage, Mrs. Louis P., 5 Sunset Dr., Troy 63379
Keller, Mrs. Robert, 712 Parr, Wentzville 63385
Kingsbury, Mrs. Robert, 3631 Collingwood
Lensenmeyer, Mrs. Charles, 455 Nantucket
Muhm, Mrs. Yale, 548 Riverside La.
Muenster, Mrs. Vincent, 39 Shawnee Dr.
Obando, Mrs. Francisco, Box C, Troy 63379
Ordoukhanian, Mrs. Tatool, 1519 Showmaker Ct., Creve Coeur 63141
Perna, Mrs. Vincent, #14 Rio Vista
Poggemeier, Mrs. William, 23 Shawnee
Rice, Mrs. Ron, 301 Oriole
Roach, Mrs. Edward, 211 Rio Vista
Roter, Mrs. Alex, 11223 Tureen, St. Louis 63141
Rother, Mrs. Paul, #7 Elmwood Park
Roxas, Mrs. Gene, 20 Anglers Ct., Lake St. Louis 63367
Schneider, Mrs. Thomas, 3716 Runnymede
Shuetz, Mrs. Alfred, 904 Indian Hills Dr.
Smoller, Mrs. Martin, 14 Colonial Hills Pkwy., Creve Coeur 63141
Stergen, Mrs. Nick, 5647 Bermuda, St. Louis 63121
Tejero, Mrs. Jonas, 4 Bellrive Ct.
Towers, Mrs. Orville W., Rt. 1, Box 1
Vafi, Mrs. Houshang, 159 Bellechasse Dr., Chesterfield 63017
Vart, Mrs. Gary, 2620 Park Ave.
Vighi, Mrs. James, 405 Spring Valley Ct., Chesterfield 63017
Wipfler, Mrs. Earl, 405 Duckett

ST. LOUIS CITY
(St. Louis)

Abel, Mrs. Oliver, III, 6549 Wydown 63105
Anglo, Mrs. Luis, 1209 Coronation Dr. 63125
Arnot, Mrs. John P., 28 Countryside La. 63131
Bandle, Mrs. Donald, 3801 January 63109
Barden, Mrs. Frank, 41 Beaver Dr. 63141
Bartlett, Mrs. Willard, Sr., 53 Westmoreland Pl. 63108
Benjamin, Mrs. Durand, 7340 Navarre Circle 63123
Bergman, Mrs. Hugo F., 2920 Moniteau Dr. 63121
Bergmann, Mrs. Dwayne, 801 S. Skinner Blvd. 63105
Bohigian, Mrs. George, 12640 W. Port Dr. 63141
Bohrer, Mrs. Harry C., 4112 Flora Pl. 63110
Bradley, Mrs. F. C., 7404 Oxford Dr. 63105
Brennan, Mrs. Daniel J., 5941 Coronado 63116
Brennan, Mrs. George A., 10546 Hanford 63128
Brennen, Mrs. Robert A., 6030 Highfield 63109
Brown, Mrs. Clyde O., 7419 York Dr. 63105
Brown, Mrs. E. Eugene, 7508 Cromwell Dr., Clayton 63105
Brown, Mrs. Seymour, 2169 Bantry La., Chesterfield 63017
Bruns, Mrs. Kenneth, 1 Salem Estates 63124
Budd, Mrs. John J., Jr., 501 Overhill Dr. 63130
Burroughs, Mrs. W. H., 7327 Pershing 63130
Burst, Mrs. Donald O., 61 Trent Dr. 63124
Cappel, Mrs. Powell B., 27 Old Westbury La 63119
Carney, Mrs. Joseph, 6625 Penrod 63139
Cherre, Mrs. Charles J., 10 Ridgetop 63117
Ciapciak, Mrs. Stanley, 30 Log Cabin Dr. 63124
Costa, Mrs. Dominic, 10 Devondale 63131
Daake, Mrs. John, 48 Portland Pl. 63108
Dalton, Mrs. Arthur R., 13133 Conway Rd. 63121
Dewald, Mrs. Paul A., 60 Conway La. 63124
Diehr, Mrs. Alvin H., Park Towers Apts., 200 S. Brentwood 63105
Dorton, Mrs. Robert, 12065 Heatherdane 63131
Dripps, Mrs. Roy, 8709 Red Oak Dr. 63126
Eades, Mrs. D. W., 6 Kingsbury 63112
Edwards, Mrs. Joseph, 610 W. Polo Dr., Clayton 63105
Eigel, Mrs. Edwin S., 10111 Hilltop Dr. 63128
Feller, Mrs. Harold, 5834 Bermuda Rd. 63121
Finn, Mrs. M. E., 47 Portland Pl. 63108
Fish, Mrs. Virgil O., 2500 Town & Country La. 63131
Fitzgerald, Mrs. Leo, 7219 Cornell Ave. 61330
Fitzgerald, Mrs. William, 6425 Rhodes 63109

Franklin, Mrs. Max, 7536 Buckingham 63105
Gandlmayr, Mrs. J. M., 13600 Peacock Farm 63141
Gantz, Mrs. John A., 10 Muirfield La. 63141
Glaser, Mrs. Martin J., 3550 Hawthorne Blvd. 63104
Glick, Mrs. Harry N., 1412 Mason Rd., Rt. 13 63131
Goldman, Mrs. Melvin, 8650 Barby La. 63124
Green, Mrs. William R., 10311 N. Sunswept 63141
Gresick, Mrs. Robert, 11 Coach-N-Four 63131
Grogan, Mrs. Frank, 4166 Flora Ave. 63110
Gunn, Mrs. Walter, 6742 Itaska 63109
Haddock, Mrs. James, 111 Firwood, Webster Groves 63119
Hall, Mrs. Preston C., 39 Woodcrest Dr. 63124
Harkins, Mrs. William, 7 Kingsbury Pl. 63112
Hassett, Mrs. Henry A., 4440 Lindell 63108
Hawk, Mrs. Bray, 3534 Hawthorne 63104
Haynes, Mrs. Pugh, 8006 Gannon 63130
Henschel, Mrs. Eugene, 55 Broadview, Clayton 63105
Hicks, Mrs. Robert, 733 Sherwood Dr. 63119
Hilbert, Mrs. Paul, 5701 Pernod 63109
Hogan, Mrs. Patrick, 9036 Laurel Crest 63126
Hollo, Mrs. Venvel W., 8 Country Estates 63131
Idewu, Mrs. Olawale, 410 N. Newstead Ave. 63108
Jablonski, Mrs. Raymond C., P.O. Box 953, St. Charles 63301
Jensen, Mrs. Joshua, 3 Brazilian Ct. 63124
Jones, Mrs. Otey, 2010 Longfellow 63104
Karandjeff, Mrs. A. D., 48 Lake Forest 63117
Karl, Mrs. Michael M., 14 Thorndell Dr. 63117
Kelly, Mrs. Robert, 5317 Waterman 63130
Kendig, Mrs. John, 841 Rolfe Dr. 63122
Klein, Mrs. Saul J., 11 Huntleigh Downs 63131
Kloecker, Mrs. Richard J., 1022 Hampton Park 63117
Kneal, Mrs. Ellsworth, 725 S. Skinner 63105
Knight, Mrs. Franklin P., 11465 Fairland Ct. 63136
Knight, Mrs. William A., Jr., 12 Briar Cliff 63124
Koon, Mrs. Bernard T., 207 Crandon Dr. 63105
Kountz, Mrs. William B., 2619 Gurney Ct. 63110
Krojanker, Mrs. Rolf J., 1060 Purdue 63130
Kronemer, Mrs. Norton, 800 Audubon Dr., Clayton 63105
Kowert, Mrs. Edward H., 330 Planthurst Dr. 63119
Kuhlman, Mrs. Robert E., 12 Upper Barnes Rd. 63124
Lau, Mrs. Luis F., 1467 Reauville Dr. 63122
Lembeck, Mrs. Joseph A., 4103 Flora Pl. 63110
Lerwick, Mrs. E. R., 40 Portland Pl. 63108
Lewis, Mrs. J. Eugene, Jr., 7129 Kingsbury Ave. 63130
Lohr, Mrs. Curtis H., 300 S. Grand Ave. 63103
Lottes, Mrs. J. Otto, 1028 Winwood Dr. 63124
Machek, Mrs. Otakar, 16 Carrswald 63105
MacNish, Mrs. James M., 229 Bompart 63119
Mathae, Mrs. George H., 3167 S. Grand Blvd. 63118
Mendonsa, Mrs. Lawrence E., 138 Ridgecrest Dr., Chesterfield 63017
Merenda, Mrs. Sam J., 45 Berry Road Park 63122
Meyerhardt, Mrs. Milton H., 665 S. Skinker 63105
Montgomery, Mrs. A. F., 18 Southcote 63144
Morfit, Mrs. John C., 7627 Wydown Blvd. 63105
Mowrey, Mrs. William, 7071 Lindell Blvd. 63130
Muether, Mrs. Raymond, 19 Country Life Acres 63131
Neilson, Mrs. Arthur W., 6349 Alexander Dr. 63105
Neun, Mrs. William F., 5862 Delor 63109
Niesen, Mrs. Frank, 1304 Brynnwood 63124
Nye, Mrs. Robert, 4910 S. Broadway 63111
Oppenheimer, Mrs. Henry E., 9444 Old Bonhomme Rd. 63132
Orenstein, Mrs. Joseph M., 417 Jackson Ave. N. 63130
Peden, Mrs. Joseph C., Jr., 51 Fair Oaks 63124
Peeler, Mrs. J. O., 10000 Knoll Crest Ct. 63136
Pennington, Mrs. F. Eugene, 27 Log Cabin 63124
Portugal, Mrs. A. Q., 10222 Gregory Ct. 63128
Powers, Mrs. Pierce W., 4 Crestwood Dr. 63105
Raybuck, Mrs. H. E., Jr., 22 Rolling Rock Ct. 63124
Razzao, Mrs. Abdul, 3283 Maryville Rd., Granite City, Ill. 62040
Rendleman, Mrs. George F., 2 Vista Brook 63124
Ritter, Mrs. Hubert A., 26 Briarcliff 63124
Rodriguez, Mrs. U. R., 10408 Daybreak 63128
Sanders, Mrs. Robert D., 4214 Flora Pl. 63110
Scheer, Mrs. George E., 53 Berkshire 63117
Schmidt, Mrs. Edwin H., 10240 Schuessler 63128
Schweiss, Mrs. John F., 1414 Westwind Dr. 63131
Sexton, Mrs. Daniel L., 14 Crestwood Dr. 63105
Shah, Mrs. Anwar, 9810 Log Cabin Ct. 63124
Shaw, Mrs. Edward, 3105 Longfellow 63104
Sherwin, Mrs. Charles S., 3971 Flora Pl. 63110
Simon, Mrs. David L., 7809 Gannon 63130
Smith, Mrs. Benjamin, 5 Fordyce Manor 63131
Smith, Mrs. Hugh R., 8836 Roack Forest Dr. 63123
Spoeneman, Mrs. Walter H., 18 Biritz Ct., Bellefontaine Neighbors 63137
Strominger, Mrs. Donald B., 701 Yale Ave. 63130
Stroud, Mrs. C. Malone, 6232 McPherson 63130
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1975-1976 Policy Manual of the Missouri State Medical Association

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This manual shall be a guide for MSMA members to the stand taken by the House of Delegates of the Missouri State Medical Association on issues involving Association policy.

The manual will be updated and revised according to House actions. The date in parentheses following each policy statement denotes the year it was adopted by the House.

Abortion

An abortion should be considered illegal if performed by anyone other than a licensed physician in a place other than a licensed hospital. (1970)

Acupuncture

The MSMA urges the Missouri State Board of Registration for the Healing Arts to utilize such legal and statutory powers as may be available to declare that the principles apparently involved in the practice of acupunture and shiatsu, if found to be scientifically valid and medically beneficial would fall under the definition of the practice of medicine. (1973)

Board of Healing Arts

The MSMA opposes any legislation which would dilute the licensing power of the State Board of Registration for the Healing Arts to license those physicians of good ethical and moral character. (1975)

Chiropractic

It is the position of the medical profession that Chiropractic is an unscientific cult whose practitioners lack the necessary training and background to diagnose and treat human disease. Chiropractic constitutes a hazard to rational health care in the U. S. because of the substandard and unscientific education approach to disease causation. (1969)

Community Professional Directories

It is not unethical for a physician to authorize the listing of his name and practice in a directory for professional or lay use which is intended to list all physicians in the community on a uniform and non-discriminatory basis. The listing shall not include any self-aggrandizing statement or qualitative judgment regarding the physician's skills or competence. The *American Medical Directory* provides an example of the kind of information that may be properly listed in national as well as community directories for health service personnel. Likewise, specialties or specialty practices used in the *American Medical Directory* should set the pattern for specialty designations. (1975)

Comprehensive Health Planning

All county medical societies are urged to take an active role in areawide CHP's by assigning a society member to be an official part of the agency. This member should make regular reports to the county and state societies on agency activities. (1974)

Confidentiality

The MSMA supports full confidentiality of patient record information provided by physicians, hospitals and other health care providers. (1975)

Drugs—Use of Combination of

The Federal Food and Drug Administration should carefully study the prescribing habits of physicians before discontinuing a combination of drugs packaged together. (1974)

Drunk Drivers

The MSMA agrees to cooperate with the Legislature or proper agencies to remedy the dangerous problem of drunk drivers. (1974)

Education—Patient

The MCMA adopts the following guidelines for third party reimbursement for patient education:

1. The goal of patient education programs shall be to improve health and the delivery of

health care services through cooperative efforts of informed patients and health professionals.

2. Patient education programs shall be provided under the guidance of an educational committee comprised of members of the health professions, and administration, and consumers.
3. Patient education committees will be responsible for the establishment, maintenance, and evaluation of all patient education programs.
4. Patient education services shall consist of planned efforts, with stated goals and objectives, based upon identifiable needs of patients and the resources of the health professionals.
5. Patient education services shall be provided under the direction of a practicing physician and a trained educator and must be appropriate to the immediate health needs of the patient.
6. Participation in such programs shall be by prescription of a practicing physician and shall be documented in the patient's chart. (1975)

Education—School Health

Factual, academically founded courses should be developed and implemented by the Missouri Department of Education to teach human physiology and pathophysiology at the elementary and secondary levels of the school system. (1974)

County medical societies are urged to work with local school districts to assist in providing comprehensive health education programs and the state colleges of Missouri are urged to prepare qualified health instructors trained to integrate health concepts into all the courses they teach. (1972)

Fluoridation

The MSMA, realizing the medical importance of natural occurring fluorine taken in proper concentration into the human body, recommends the adding of fluorine to all drinking water systems in Missouri in the concentration of one part per million. (1972)

Home Health Care

The concept of home health care and visiting nurses care as a proper and economical way to bring quality health care to Missouri citizens not requiring more expensive and acute care is favored by the Association. (1972)

Hospital—Preadmission Certification

The MSMA will continue to oppose implementation of hospital preadmission certification. (1974)

Insurance—Charge for Extra Claim Forms

Physicians should feel free to charge for the additional service of filing more than one insurance claim form, especially if a different claim form is required rather than a photocopy of the original claim form. (1973)

Insurance—Maternity Coverage

The MSMA supports inclusion in all insurance policies for those in childbearing years of a clause providing complete maternity coverage.

In order to provide continuity of coverage, the following eligibility period should be written into all insurance policies concerning benefits for obstetric care: "A pregnancy which begins while the insurance is in force should be covered until the termination of the puerperium and until the newborn infant is discharged from the hospital to home care." (1974)

Insurance—Mental Illness

The MSMA supports a state health insurance act which would require minimum inpatient and outpatient mental health benefits in all health insurance policies issued in Missouri. (1974)

Licensing—Felon

As a general rule, the MSMA opposes the granting of a license to practice medicine to any physician who has been convicted of a felony. (1973)

Licensing—FGMs

The MSMA endorses the policy of accepting the "Fifth Pathway" for physician licensure in Missouri. (1975)

Medical Examiner System

The establishment of the county medical examiner system as a replacement for the county coroner system is strongly recommended. (1971)

National Health Insurance

Any system of national health insurance must be designed with the consultation and aid of practicing physicians with the welfare of the patient as the guiding principle. A mechanism should be provided so the patient realizes the value of medical services to the point of real participation in the payment for those services. (1974)

The MSMA endorses the American Medical Association's "Medicredit Bill" as the national health insurance plan best suited to maintaining the high quality of American Medicine. (1973)

Osteopaths—Association With

Medical doctors may consult or associate with Doctors of Osteopathy and participate in postgraduate education specifically designed for their needs. (1965)

Osteopaths—Membership

Both local and state medical societies may accept for full membership osteopathic physicians who are licensed to practice medicine in Missouri. (1970)

Physician Assistants

The use of physician assistants by primary physicians and the use of specialty assistants, trained under guidelines of their respective specialties, is favored where the use of such assistants will greatly increase the availability and quality of medical care. The MSMA encourages the development of training programs for physician assistants under guidelines of accreditation as prepared by the AMA and favors passage of such legislation which will place control of physician assistants under the Missouri Board of Healing Arts. (1972)

PSRO

THE MSMA recommends a two-year trial period for PSRO in government-owned and operated hospitals before the law is applied to the private sector. A report on the benefits derived and the problems encountered would be made following the trial period. (1975)

If the Department of Health, Education and Welfare fails to return control of PSRO to the local level, the MSMA will promote non-participation by physicians, take appropriate legal action and, if these actions are unsuccessful, will work for the repeal of Public Law 92-603. (1975)

Regional Medical Program

The Federal Regional Medical Program is recognized as an effective force responsible to the private sector of the health care system for improved health care. (1973)

Seat Belts

The MSMA favors passage of state laws requiring use of seat belts in motor vehicles. (1974)

Unpaid Accounts—Interest

It is not in the best interest of the public or the profession to charge interest on an unpaid bill or note for professional services not paid within a prescribed period of time nor is it proper to charge a patient a flat collection fee if it becomes necessary to refer the account to an agency for collection.

It is not improper, however, for a physician to add a service charge, equal to the actual cost of rebilling, on accounts not paid within a reasonable time. Patients must be notified in advance about the existence of this practice. (1975)

(If you have questions on these or other policy matters, please contact the Missouri State Medical Association, Box 1028, Jefferson City, Mo. 65101. Tel.—(314) 636-5151)

Remember These Dates!

The 118th

ANNUAL SESSION

of the

Missouri State Medical Association

will be held on

APRIL 1-4, 1976

Crown Center Hotel Kansas City

"Without your help

. . . I simply would not have made it through medical school!"

(The following letter was received on Oct. 1, 1971 from a physician who, as a student, received financial assistance from the Missouri State Medical Association members who have contributed to the Missouri State Medical Foundation. It is printed with his permission.)

Dear Doctor:

"Thank you very much for your thoughtful letter concerning receipt of my final payment on my medical student loan.

"I can well remember the feeling of destitution associated with being a reasonably good student but lacking funds with which to enroll for the next semester in medical school. Having always been, perhaps, more than adequately endowed with pride, it was a lesson in discipline and humility to go seeking financial assistance. However, the effort brought me in contact with some very nice people who really do a lot to keep one's faith in human nature alive.

"I sincerely appreciate the efforts which you and others put into the Missouri State Medical Foundation and all other student loan funds. You should feel a quiet heroism for the assistance you lend to needy students . . . without your help, I simply would not have made it through medical school."

The Missouri State Medical Foundation—MSMF—was created by the Missouri State Medical Association for the express purpose of giving financial assistance to deserving young Missourians who will be tomorrow's doctors.

Send a Check Today to MSMF!

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Missouri Medicine

JOURNAL OF THE MISSOURI STATE MEDICAL ASSOCIATION

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AUGUST, 1975
VOLUME 72, NUMBER 8

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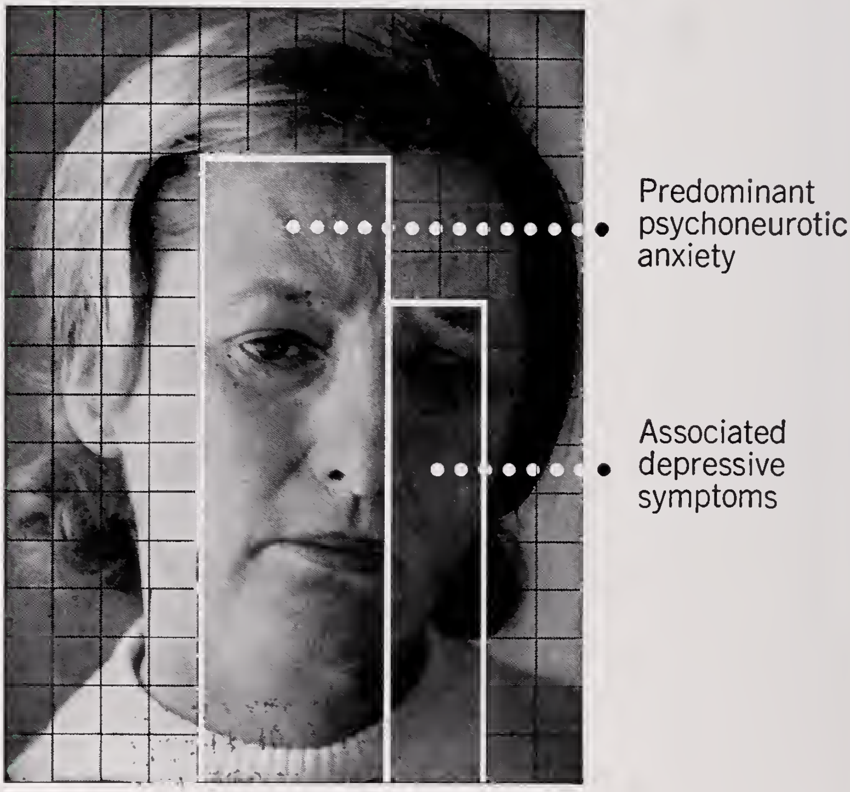
Both often


Predominant psychoneurotic anxiety
Associated depressive symptoms

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in fr
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the depressive symp-
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elieved.

here are other advan-
n using Valium for the
gement of psychoneu-
nxiety with secondary
sive symptoms: the
otherapeutic effect of
n is pronounced and
This means that im-
nent is usually apparent in the patient within a few days rather than in a week or two, although it may take longer in some patients. In addition, Valium (diazepam) is generally well tolerated; as with most CNS-acting agents, caution patients against hazardous occupations requiring complete mental alertness.

Also, because the psychoneurotic patient's symptoms are often intensified at bedtime, Valium can offer an additional benefit. An *h.s.* dose added to the *b.i.d.* or *t.i.d.* treatment regimen can relieve the excessive anxiety and associated depressive symptoms and thus encourage a more restful night's sleep.

Valium®
(diazepam)

2-mg, 5-mg, 10-mg tablets

in psychoneurotic
anxiety states
with associated
depressive symptoms

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OF PHILADELPHIA

AUG 28 1975

ance because of their predisposi-
habituation and dependence. In
ncy, lactation or women of child-
age, weigh potential benefit
possible hazard.
tions: If combined with other psy-
ics or anticonvulsants, consider
ly pharmacology of agents em-
drugs such as phenothiazines,
cs, barbiturates, MAO inhibitors
er antidepressants may potentiate
on. Usual precautions indicated in
s severely depressed, or with latent
sion, or with suicidal tendencies.

Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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Nutley, New Jersey 07110

Missouri Medicine

THE JOURNAL OF THE MISSOURI STATE MEDICAL ASSOCIATION

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Illustrations should be glossy prints or drawings in India ink on white paper. They should not be mounted and name of author and figure number should be penciled lightly on the backs. Legends should appear on a separate sheet. Colored illustrations will be used when suitable if author assumes the actual cost.

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ontents for August, 1975

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NO.4—for pain intensity below the need for injectables

As a rule, only pain that requires morphine is beyond the scope of Empirin® Compound with Codeine No. 4. That's because it delivers a full grain of codeine. (In the preferred phosphate form.) Its antitussive action is particularly appreciated by patients with fractured ribs, and following chest or abdominal surgery. Its low addiction liability is a bonus for all patients who require potent analgesia.

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Wherever it hurts
EMPIRIN® COMPOUND c̄ CODEINE

No.3, codeine phosphate*(32.4 mg) gr ½ : No.4, codeine phosphate*(64.8 mg) gr 1

*Warning—may be habit-forming.

Each tablet also contains aspirin gr 3½, phenacetin gr 2½, caffeine gr ½.

MSMA

NEWS ROUND-UP

AUGUST, 1975

nges in Missouri law

Proposed malpractice bills heard

roposed legislation which would drastically change h laws governing medical malpractice was discussed t meeting of the Missouri State Senate Select Com- ee on Malpractice, July 23-24 in St. Louis.

hirty-one witnesses, including 21 M.D.'s, testified at hearing. However, the number of physicians at- ding the important meeting was considered disap- ntingly low. Invitations to attend were mailed to physicians by both Sen. Albert Spradling, Commit- chairman, and Dr. August W. Geise, Jr., President he St. Louis Medical Society.

he Committee heard testimony and presented afts" of proposed legislation which they intend to ne and pre-file early in December, preceding the t Session of the Missouri General Assembly which ins in January 1976.

ome of the provisions in the "drafts" called for:

. A ceiling of $500,000 on the total amount recoverable.

. Fees of plaintiff's attorney would not exceed 33 1/3% of any amount awarded. This may be changed to a sliding scale arrangement later.)

3. Statute of Limitations on minors would be changed. They would come under the regular "two years from the date of the alleged act" statute except that a minor under the age of six shall have until his eighth birthday in which to file.

4. The establishment of medical malpractice review boards in each Congressional District of the state. Hearings would be held by a Circuit Court judge appointed by the Chief Justice of the Supreme Court. The hearing would be informal except the Board would prepare a formal statement of its recommendations which would be admissible as evidence. A tax on professional liability carriers would fund the operation. The makeup of the Board will be studied further.

The Senate Committee has scheduled a special hearing for 10 a.m., August 21, at the Colony Hotel in St. Louis to receive testimony from representatives of professional liability insurance companies. The Committee has requested the companies to justify their premium increases.

Further hearings are tentatively planned later in the year in Cape Girardeau and Mid-Missouri.

County officer meeting planned at Lake Ozark

A meeting of County Medical Society Officers will be held Oct. 17-18 at the Lodge of the Four Seasons at the Lake of the Ozarks.

A special committee called for by the House of Delegates and appointed by the MSMA President agreed that the meeting will focus on matters of concern to Missouri physicians. These may be state or national, but will also include subjects concerning local societies.

"In many cases," said Committee Chairman, Dr. John Laird, St. Louis County, "one county society may be facing a problem which has already been solved by another county. This meeting will enable us to exchange ideas."

County Society Presidents and and President-Elects will be invited to the meeting. However, if these officers are unable to attend, they may designate replacements.

Manpower bill amended before passing House

Following intense pressure from the AMA, state medical societies and other medical organizations, the U.S. House amended the Federal Health Manpower Bill (HR 5546) to eliminate one objectionable clause and water down another.

One amendment eliminated the proposal which would have placed the control of residency programs under the federal government.

Although the provision calling for medical students to repay the government for capitation grants given medical schools (or serve in an area of need) was passed by the House, it was somewhat weakened by amendments which exempted present students, deferred initiation of payback requirements until two years after completion of training and eliminated the payback for graduates service in the armed forces.

Medical News-in-Brief

Members invited to help

MSMA members have recently received an invitation to participate in a special Immunization Action Month campaign designed to increase the level of immunization among Missouri children.

Sponsored by the MSMA, MSMA Auxiliary and the Missouri Division of Health, the focus of the campaign is to have MSMA members include an "Immunization Timetable" and "Immunization Record" with their October billings to patients.

The Timetable and Record are to be furnished to participating physicians without charge and are designed to fit into a regular billing envelope. Also, the material is printed on lightweight paper and will not require additional postage.

Each MSMA member received a letter of explanation from Auxiliary President, Mrs. William R. McPhee, and a Return Card for ordering the proper number of free pamphlets. The Auxiliary is to coordinate the project and the Division of Health will furnish the material.

The letter pointed out that immunization levels in Missouri, as across the nation, are not high enough to prevent some outbreaks. This is despite the fact that vaccines are readily available.

Official Missouri figures indicate the following immunization levels of children entering school in 1974: DPT — 81.2%; Measles — 81.4%; Polio — 77.2%; Rubella — 77.4%.

By including a copy of the "Immunization Timetable" and "Record" with your billing, it is hoped that your patients will realize the importance you, their physician, places upon immunization.

In an effort to gain as widespread coverage as possible, all specialities are urged to participate in the mailing, regardless of whether they give immunizations.

For further information on this subject, contact MSMA Headquarters.

Planning meeting set

A statewide meeting on the National Health Planning and Resources Development Act of 1974 (PL 93-641) will be held at 2 p.m. Tuesday, Aug. 19, in Jefferson City.

The meeting will be cosponsored by the Missouri Regional Medical Program and the Missouri Division of Social Services. Gov. Christopher Bond has designated the Social Services Division as the state's Health Resources and Development Agency.

Rush nominations open

Nominations are open for the annual Dr. Benjamin Rush Bicentennial Award for Citizenship and Community Service. The $5,000 award is presented each year at the AMA Clinical Convention.

The award is given to a U.S. citizen possessing an MD degree or its equivalent who has made an outstanding contribution to the community for citizenship and service above and beyond the duty of a practicing physician.

Nominations may be made by any individual or organization and should include the candidate's currciulum vitae, documentation of qualifications for the award, a brief statement summarizing accomplishments and any other supportive material.

Deadline for receipt of nominations is Sept. 1, 1975. Submit nominations to the office of the Executive Vice President, AMA Headquarters, 535 North Dearborn St., Chicago, Ill. 60610.

Council to meet Sept. 13

The next meeting of the Council of the MSM will be held Saturday, Sept. 13, at t Breckenridge Inn in St. Louis. The meeting w begin at 9 a.m.

HMO amendments opposed

Proposed amendments which would "gut" the requirement the Health Maintenance Organization (HMO) law have been posed by the AMA and MSMA.

Testifying before the House Commerce subcommittee Health, the AMA said enactment of the weakening amendme would "convert a demonstration health delivery program int mechanism for the funding of ordinary prepaid groups."

The amendments would switch some of the services offered HMO's from required to supplemental and, more importa would make the provision of supplemental and, more importa would make the provision of supplemental services merely an tion of the HMO. The original argument used in passage of HMO law was that such a group would offer ALL necess health services to its enrollees.

Telephone listing change

AT&T has mailed a press release to major newsp pers announcing the introduction of a new guide medical specialties as part of the "Physicians and Su geons (M.D.)" heading in the yellow pages.

Physicians will be invited to supplement their reg lar, alphabetical listing with an extra listing und their specialty.

The press release states the new listing will serve a local guide to approved AMA specialty designatio

Although the AMA received advance information the new guide, the plan has not been reviewed by a official body of the Association. Therefore, it is reco mended that each local society should becor thoroughly familiar with the proposal, and when in cated, urge modifications to conform with local ethic considerations.

In addition, local societies may wish to consider pa ing for a small announcement at the head of t specialty listing stating complete information on me ber physicians is available through the medical societ

In 1966 the AMA Judicial Council publish Guidelines for Telephone Directory Listings for Phy cians and Surgeons. These guidelines provide for specialty designation directly under the physicia name.

AMA lawsuit upheld

A three-judge U.S. Court of Appeals recently uphe the AMA's preliminary injunction enjoining HEW fro enforcing the controversial utilization review regul tions originally scheduled to become effective in Febr ary, 1975.

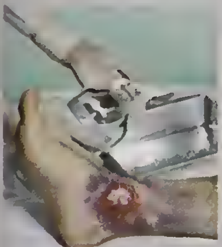
The court denied the Federal government's appeal set aside a preliminary injunction issued last May Judge Julius Hoffman. Judge Hoffman is expected rule soon on the AMA's suit for a permanent injuncti to prohibit enforcing the review regulations.

The court action was the first taken by the AM against the Federal government. A complete report a pears in the July 28, 1975, issue of *American Medical Nev*

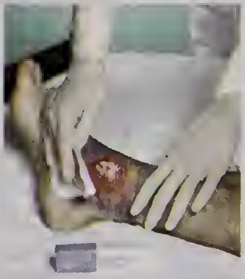
adjunctive therapy for wound debridement

HELPS TO REMOVE:
- Necrotic Tissue and Associated Odor

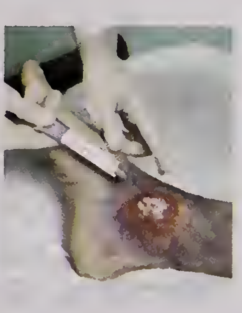
HELPS PREPARE WOUND FOR:
- Granulation/Healing
- Granulation/Grafting



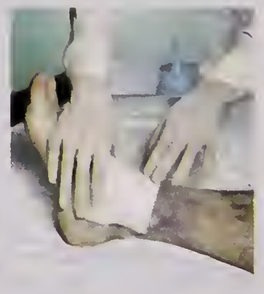
CLEANSE WOUND
Thoroughly cleanse and irrigate wound area with sodium chloride or water solutions. Wound MUST be cleansed of antiseptics or heavy-metal antibacterials.



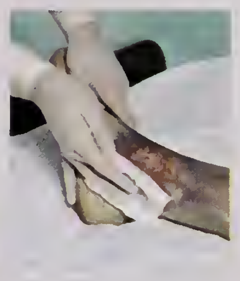
THOROUGHLY MOISTEN
Thoroughly moisten wound area either through tubbing, showering, or wet soaks (e.g., sodium chloride or water solutions).



APPLY ENZYME
Apply a layer of TRAVASE Ointment. Assure intimate contact with necrotic tissue and complete wound coverage.

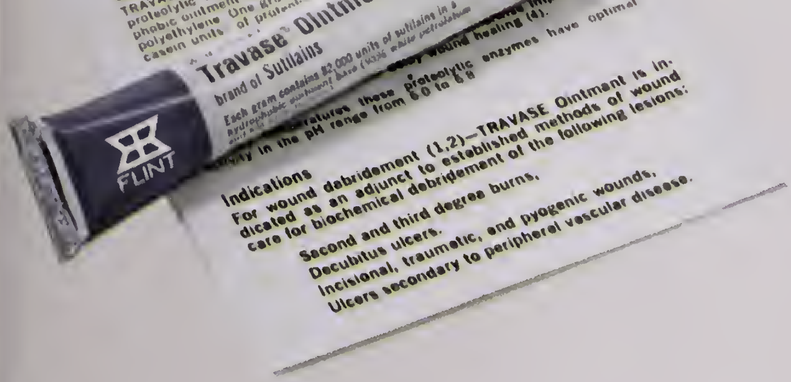


APPLY MOIST DRESSING
Apply loose moist dressings (most important with dry leathery eschar).



CHANGE DRESSINGS
When changing dressing, gently wipe away the dissolved material. Repeat the procedure, including application of TRAVASE Ointment, 3 to 4 times per day for best results.

Travase® Ointment
brand of Sutilains


Travase® Ointment
brand of Sutilains
Each gram contains 82,000 units of sutilains in a hydrophobic ointment base (95% white petrolatum
FLINT
REFRIGERATE

Travase® Ointment
brand of **Sutilains**

Description
TRAVASE® (brand of sutilains) Ointment is a sterile preparation of proteolytic enzymes, elaborated by Bacillus subtilis, in a hydrophobic ointment base consisting of 95% white petrolatum and polyethylene. One gram of ointment ... casein units of proteolytic ...
... impair formation of new ... wound healing (4).
... temperatures these proteolytic enzymes have optimal activity in the pH range from 6.0 to 6.8.

Indications
For wound debridement (1,2)—TRAVASE Ointment is indicated as an adjunct to established methods of wound care for biochemical debridement of the following lesions:

Second and third degree burns,
Decubitus ulcers,
Incisional, traumatic, and pyogenic wounds,
Ulcers secondary to peripheral vascular disease.

FLINT LABORATORIES
DIVISION OF TRAVENOL LABORATORIES, INC.
Deerfield, Illinois 60015

Please see next page for prescribing information.

Travase® Ointment brand of Sutilains

ulcers

TERRY V. CARLE, M.D., CLINICAL INSTRUCTOR, DEPT. OF PHYS. MED. & REHAB.,
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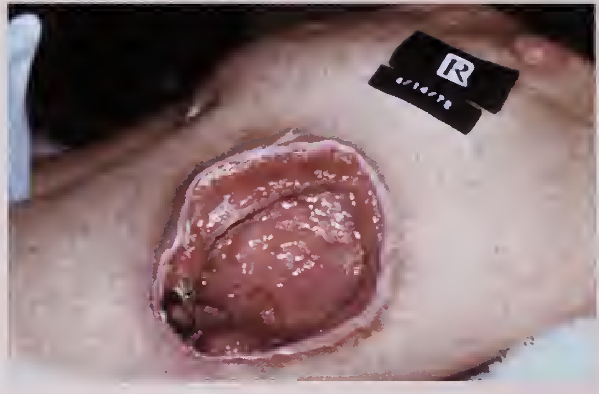
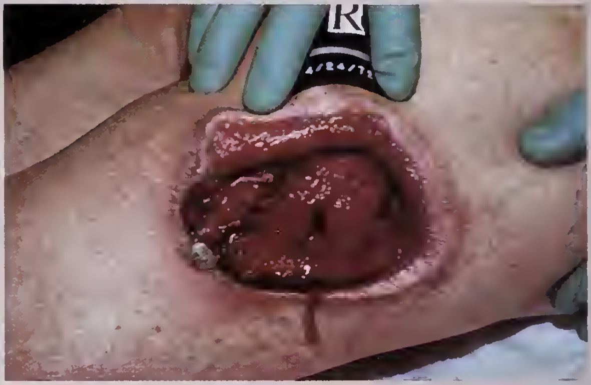


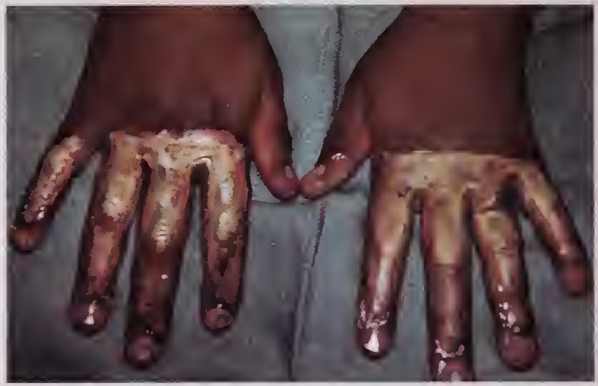
Before treatment, necrotic matter coated the inner surfaces of this decubitus ulcer.



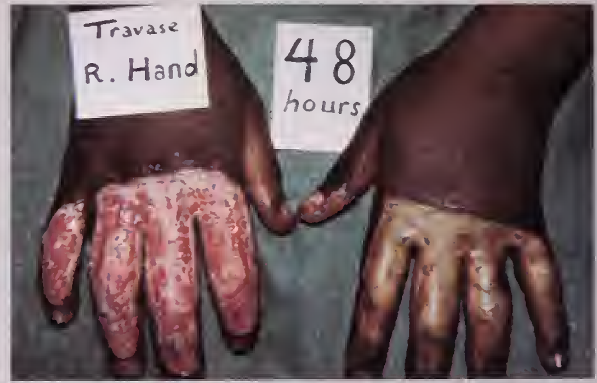
After nine days of TRAVASE therapy, debridement is nearly complete and granulation evident.

burns

DALE B. DUBIN, M.D., DIPLOMATE,
AMERICAN BOARD OF PLASTIC SURGERY, TAMPA, FLORIDA



Before treatment . . .



48 hours following treatment with TRAVASE Ointment on right hand; left hand is control.

Travase® Ointment

(brand of Sutilains)

Indications: For wound debridement, TRAVASE Ointment is indicated as an adjunct to established methods of wound care for biochemical debridement of the following lesions:

Second and third degree burns,
Decubitus ulcers,
Incisional, traumatic, and pyogenic wounds,
Ulcers secondary to peripheral vascular disease.

Contraindications: Application of TRAVASE Ointment is contraindicated in the following conditions:

Wounds communicating with major body cavities,
Wounds containing exposed major nerves or nervous tissue,
Fungating neoplastic ulcers,
Wounds in women of child-bearing potential—because of lack of laboratory evidence of effects of TRAVASE upon the developing fetus.

Warning: Do not permit TRAVASE Ointment to come into contact with the eyes. If contact is made, immediately rinse with copious amounts of water, preferably sterile.

Precautions: A moist environment is essential to optimal activity of the enzyme. Enzyme activity may also be impaired by certain agents (see package insert). Although there have been no reports of systemic allergic reaction in humans, studies have shown that there may be an antibody response in humans to absorbed enzyme material.

Adverse Reactions: Consist of mild, transient pain, paresthesias, bleeding and transient dermatitis. Pain usually can be controlled by administration of mild analgesics. Side effects severe enough to warrant discontinuation of therapy occasionally have occurred.

If bleeding or dermatitis occurs as a result of the application of TRAVASE Ointment, therapy should be discontinued. No systemic toxicity has been observed as a result of the topical application of TRAVASE Ointment.

DOSAGE AND ADMINISTRATION: STRICT ADHERENCE TO THE FOLLOWING IS REQUIRED FOR EFFECTIVE RESULTS OF TREATMENT:

1. Thoroughly cleanse and irrigate wound area with sodium chloride or water solutions. Wound MUST be cleansed of antiseptics or heavy-metal antibacterials which may denature enzyme or alter substrate characteristics (e.g., hexachlorophene, silver nitrate, benzalkonium chloride, nitrofurazone, etc.).
2. Thoroughly moisten wound area either through tubbing, showering, or wet soaks (e.g. sodium chloride or water solutions).
3. Apply TRAVASE Ointment in a thin layer assuring intimate contact with necrotic tissue and complete wound coverage extending ¼ to ½ inch beyond the area to be debrided.
4. Apply loose wet dressings.
5. Repeat entire procedure 3 to 4 times per day for best results.

FLINT LABORATORIES
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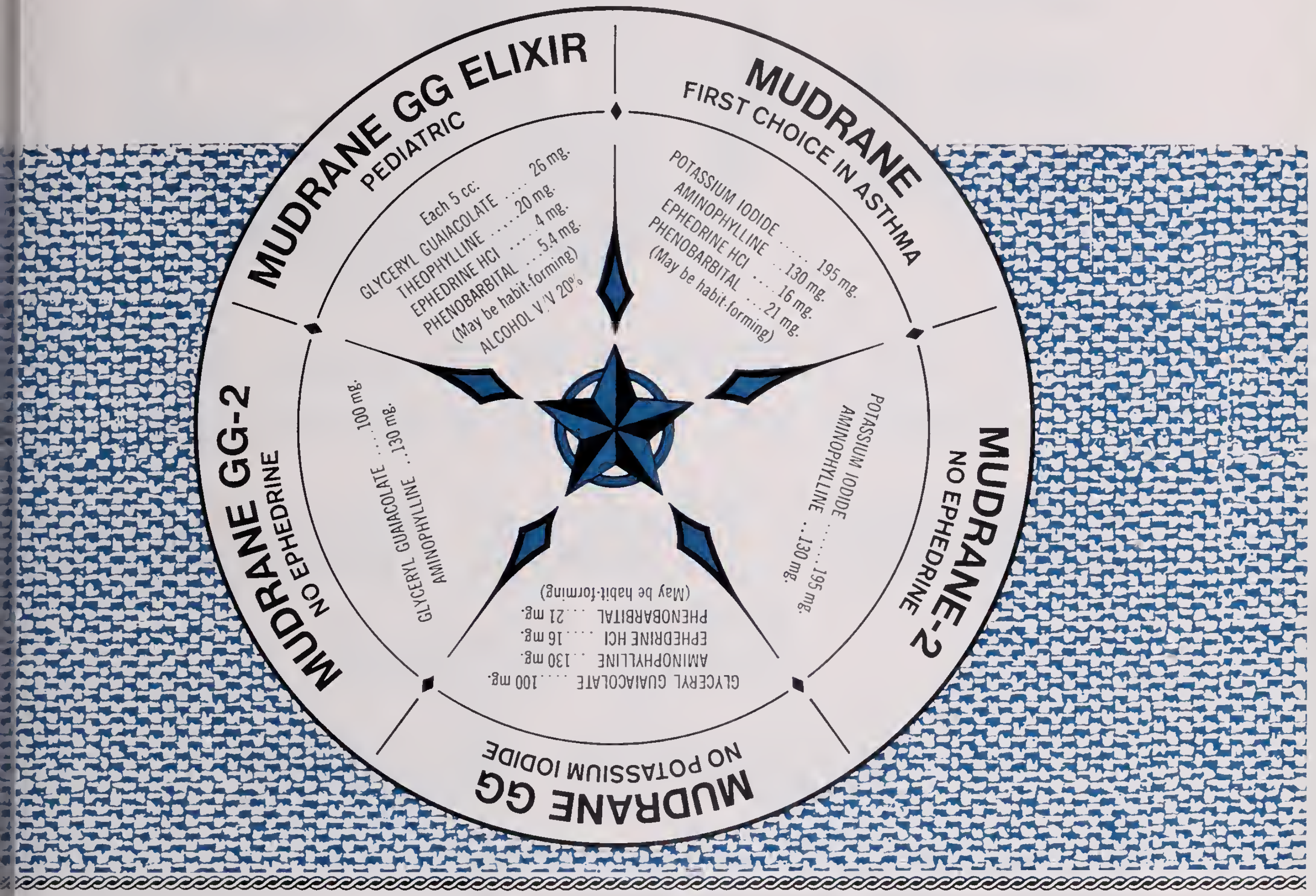
The MUDRANES

Discreet formulations of four well regarded drugs for the relief of bronchial distress—Potassium Iodide, Glyceryl Guaiacolate, Aminophylline, Ephedrine with Phenobarbital (to lessen cardiac stimulation).



MUDRANE GG ELIXIR
PEDIATRIC
Each 5 cc:
GLYCERYL GUAIACOLATE . . . . 26 mg.
THEOPHYLLINE . . . . . 20 mg.
EPHEDRINE HCl . . . . 4 mg.
PHENOBARBITAL . . . 5.4 mg.
(May be habit-forming)
ALCOHOL V/V 20%

MUDRANE
FIRST CHOICE IN ASTHMA
POTASSIUM IODIDE . . . . . 195 mg.
AMINOPHYLLINE . . . 130 mg.
EPHEDRINE HCl . . . . 16 mg.
PHENOBARBITAL . . . 21 mg.
(May be habit-forming)

MUDRANE-2
NO EPHEDRINE
POTASSIUM IODIDE . . . . . 195 mg.
AMINOPHYLLINE . . 130 mg.

MUDRANE GG
NO POTASSIUM IODIDE
GLYCERYL GUAIACOLATE . . . . 100 mg.
AMINOPHYLLINE . . 130 mg.
EPHEDRINE HCl . . . . . 16 mg.
PHENOBARBITAL . . . 21 mg.
(May be habit-forming)

MUDRANE GG-2
NO EPHEDRINE
GLYCERYL GUAIACOLATE . . . . 100 mg.
AMINOPHYLLINE . . 130 mg.

INDICATIONS: For the prompt symptomatic relief of bronchial asthma, emphysema and bronchiectasis. The Mudranes dilate the bronchi and liquefy mucus plugs. DOSAGE: Tablet; One tablet with a full glass of water 3 or 4 times daily as required. Divide tablet for child's dose. Elixir; Children, 1 cc for each 10 lbs. of body weight. May be repeated 3 or 4 times a day. Adult, one tablespoonful 4 times daily. All doses should be followed with a glass of water.

CONTRAINDICATIONS: Aminophylline/Theophylline is contraindicated in the presence of severe cardiac arrhythmias and patients with massive myocardial damage. Ephedrine, in presence of severe heart disease, extreme hypertension, and in hyperthyroidism. Phenobarbital, in porphyria and in patients with known phenobarbital sensitivity. Potassium Iodide, in pregnancy (to protect the fetus against possible iodine-induced depression of thyroid activity), in tuberculosis (produces gumma dissolution), and in acne; also in the presence of known iodide sensitivity. PRECAUTIONS: Aminophylline/Theophylline should be avoided in patients with massive myocardial damage and/or severe cardiac arrhythmias. In children, overdose may cause vomiting, cardiac arrhythmias, and severe agitation. Ephedrine should be used with caution in the presence of severe cardiac disease, particularly arrhythmias and angina pectoris; avoid in hyperthyroidism and severe hypertension. Phenobarbital may be habit-forming. Avoid overdosage. Potassium Iodide: Discontinue in the presence of skin rash, swelling of the eyelids and severe frontal headache. Long use may cause goiter. ADVERSE REACTIONS: Aminophylline/Theophylline may cause nausea, cardiac arrhythmias, and aggravate severe myocardial disease. It may cause headaches and tachycardia. Vomiting and dizziness are not uncommon. Ephedrine: In patients hypersensitive to CNS stimulation, ephedrine may cause nervousness, tachycardia, extrasystole and ventricular arrhythmias. May cause urinary retention, especially in the presence of partial prostatic obstruction. Psychoneurosis may be aggravated. Pre-existing anginal pain will be aggravated. Phenobarbital may produce severe skin rash. Avoid overdosage. May be habit-forming. Potassium Iodide may cause nausea. Over very long period of use, iodides cause goiter. Discontinue if patient develops skin rash, eye irritation, eyelid swelling, or severe frontal headache.

HOW SUPPLIED: Mudrane and Mudrane GG available in bottles of 100 and 1000 tablets; Mudrane-2 and Mudrane GG-2 in 100s; Elixir in pints and half-gallons.

Federal law prohibits dispensing without prescription.

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The Council Reports

Meeting of May 31, 1975

Ioward J. McAlhany, M.D., Springfield, Chairman, called tl meeting to order. Those present were Drs. McAlhany; R Allen Chandler, Kansas City; Max S. Franklin, St. Louis; R hard V. Bradley, St. Louis; John 1. Matthews, Jefferson C y; John N. Martin, St. Joseph; J. Russell Comer, Hannib Donald R. Judd, St. Louis; Louis P. Hetlage, Troy; R ert Tanner, Jefferson City; Andrew McCanse, Kansas C y; C. W. Cooper, Thayer; E. T. Hansbrough, Poplar B ff; Stanley S. Peterson, Springfield; George Thoma, St. L uis; Wm. C. Allen, Columbia; R. K. Noback, Kansas City; M . Wm. R. McPhee, Kansas City; Messrs. Allen D. Smith, K sas City; Hollister S. Smith, St. Louis; Gary L. Schnedle Springfield; Ray McIntyre, Royal O. Cooper, C. C. S rens, Ron Ellison and Don Wilson, Staff.

hairman McAlhany opened the meeting by introducing t new members of the Council, Drs. Bradley and Comer a indicated that Dr. Tanner was serving as Vice-Coun r for Dr. Bregant of the Fifth District. He then called for a roval of the minutes of the Council Meeting held on A il 20, 1975. On motion, duly seconded, these minutes w e approved as printed.

REPORT OF THE EXECUTIVE SECRETARY

Ir. McIntyre called the Council's attention to the fact tl at the April 16 meeting, the Council commended the M souri Dental Association for its efforts and wished the a ciation well on its proposed program for taking blood p ssures of dental patients. The Dental Association, at its r ent Annual Meeting, made note of the MSMA Council a on.

Ir. McIntyre reported to the Council regarding a letter w tten by Governor Bond to HEW expressing his strong obje ions to the National Health Planning and Resource Dev opment of 1974, along with his recommendations for dev opment Act of 1974, along with his recommendations for d ignated Health Service Areas in Missouri, as required u ler Public Law 93-641.

he Mid-Missouri PSRO has requested from the Medical A ociation an endorsement for their efforts to become desig ated as the reviewing agency for Area II. They were g en MSMA endorsement originally for their planning g nt and are now requesting endorsement for their addit al grants. Apparently, HEW requires such endorsement. C motion of Dr. Hetlage, duly seconded, the Council a eed to give such endorsement to Mid-Mo PSRO.

short note was read from one of the 50-year physicians e ressing his gratitude and pride on receiving his MSMA 5 year pin this year.

Ir. Ellison reported that there will be a meeting of the A Hoc Committee on the 118th Annual Session held on J e 28. Members of the Commission on Interspecialty M dicine will be polled by mail regarding their comments o the 1976 meeting. Following the meeting of the 28th, tl specialty organizations will be contacted in regard to h many sessions they wish to sponsor at the 1976 meeti

Ir. McIntyre reported that as most everyone knew, the A A has won the first round in the law suit regarding the n v HEW utilization review regulations for Medicare and M dicaid hospital admissions.

The preliminary injunction blocks the proposed effective date of July 1, 1975.

There are some objectionable features in a proposed manpower bill which is now before the House of Representatives in Washington—HB 5546. The two most objectionable features which are causing much concern to the medical profession are (1) the limiting and controlling of the number of various residency programs in this country and (2) the second has to do with capitation for medical education. Medical schools which take any federal aid would have to write contracts with their students and the student would agree to pay back $2,000 per year or in lieu of that he could practice in an area which would be designated by HEW. Representative Symington on the House Committee which considered this bill has been contacted regarding the bill and the other Missouri Congressmen will be contacted. The Council members were urged to get in touch with their Congressmen concerning this bill. This will come up for vote sometime around June 12.

COUNCILOR DISTRICT REPORTS

District #1—Dr. Martin indicated that he had no formal report, but he did submit the following resolution:

> WHEREAS, John A. Hailey has, for 29 years, served the citizens of the state of Missouri as Executive Secretary of the State Board of Medical Examiners and, later, the State Board of Registration for the Healing Arts, and
>
> WHEREAS, Mr. Hailey's dedicated service to the Board and to the medical profession in general has greatly assisted in a smooth working relationship between the licensing board and the physicians of Missouri, and
>
> WHEREAS, During Mr. Hailey's distinguished term of service more than 17,000 people were licensed to practice by the Board; therefore, be it
>
> *Resolved*, That the Missouri State Medical Association express its heartfelt appreciation to John A. Hailey for a job well done.

On motion of Dr. Martin, duly seconded, the above resolution was unanimously adopted.

District #2—Dr. Comer reported that the Mark Twain Mental Health Center has been established in Hannibal and seems to be getting off to a good start. Dr. Comer further reported that Hannibal will be acquiring four more physicians in the near future.

District #3—Dr. Judd indicated that the No. 1 topic on physicians' minds in his district is the malpractice situation. With this in mind, Dr. Judd made the following motion. He moved that the State Association send a letter of the MSMA membership informing them of the efforts of this Association and the legislative efforts being made in the field of malpractice. Motion was seconded and carried.

District #4—Dr. Hetlage reported that his Fourth Councilor District representatives met on May 28 and discussed many topics. They discussed the American Federation of Physicians and Dentists. They had mixed feelings on this matter. However, it was indicated that some mechanism of protest against third parties must be provided.

The Fourth Councilor District approved the proposal for a Unit System for Hospital Data Providers and Users.

Dr. Hetlage reported that Don Wilson, MSMA Field Secretary, attended his meeting and discussed several items such as updating them relative to the AMA suit against HEW; discussed Public Law 93-641 and much discussion was held regarding the assignment of Health Service areas under this law. The Fourth District Councilor expressed his concern over the manner in which assignments were made.

The Fourth District voted to vigorously oppose the Health Manpower Act, HR 5546, through contact with local congressmen.

Discussion was held regarding malpractice legislative proposals, particularly those hearings being held by the House and Senate Special Committees and the Governor's Task Force.

MSMI was discussed and there was general feeling of lack of communication and detailed information about the program and the Fourth District suggested that immediate detailed circularization of the membership take place.

The plan for continuing medical education was updated. The Councilor was asked to divide the Fourth District into geographic regions and to appoint co-chairmen to implement the program.

A proposal was made to have a joint meeting of societies in the Fourth District so the discussion of common problems could be held.

Dr. Hetlage reported that MSMA encourages physician participation in CHP activities. However, in his particular area, the scheduling of meeting times is very unsatisfactory. It was suggested that the only adequate way of representing the profession would be to nominate members of county medical staffs to provide input designated by the local society.

The Fourth District stands firmly against the increase in dues as proposed by the Board of Trustees of the AMA and suggests to the AMA that large savings could be accomplished by cleaning out much of the deadwood in publications and other efforts of the AMA.

Dr. Hetlage said that a detailed discussion was held concerning policies of St. Louis Blue Cross, particularly their policy of paying per diem costs rather than billed charges. Dr. Hetlage moved that the matter of St. Louis Blue Cross be given to the Medical Economics Commission for a detailed study and possibly an Ad Hoc Committee on Blue Cross should be established. Motion was seconded and carried. Dr. Hetlage stressed that the criticism does not extend to Blue Shield, for they feel Blue Cross is functioning entirely independently of Blue Shield.

Dr. Hetlage submitted the following resolution, approved by the Fourth District, to be delivered to the AMA, probably too late for this coming session, but, hopefully, in the Interim Session in Hawaii:

Whereas, Missouri State Medical Association, House of Delegates, at its 110th Annual Meeting in March, 1968, passed a resolution calling for training of osteopathic graduates in medical postgraduate training programs, and

Whereas, The American Medical Association House of Delegates confirmed and reinforced this action at its meeting in December, 1968, and

Whereas, Since that time, there have been increasing numbers of osteopathic trainees in accredited medical residency programs throughout the country, and

Whereas, It has been the experience of these trainees that following completion of some accredited residency programs, neither the Medical or Osteopathic Board certification examinations have been made available to them, and

Whereas, This is an unreasonable and prejudicial policy in light of the action taken by the AMA in 1968, therefore be it

Resolved, That the Council of the MSMA calls this matter to the attention of the AMA with the recommendation that the proposal be studied by the Board of Trustees and recommendations be made for the correction of this situation.

On motion of Dr. Hetlage, duly seconded, it was agreed that this resolution be submitted to the AMA.

Discussion followed regarding the letter written by Governor Bond to HEW expressing his objections to the National Health Planning and Resource Development Act of 1974. Although the Governor's Health Service Area designations did not conform with our suggestions, it was felt that we should commend his stand against the Federal Program set up in this law—PL 93-641.

Motion was made, seconded and carried that such a le be directed to the Governor.

District #5—Dr. Tanner indicated that he had no for report at this time.

District #7—Dr. McCanse reported that Jackson Co ty's TEL-MED program seems to be working very well is receiving 400 to 500 calls per day. He indicated that remainder of his report would be covered later on in meeting.

District #8—Dr. McAlhany reported that Dr. Malc Todd, AMA President, will be in Springfield on Septem 29 and 30 and invited those present at the meeting to tend.

Mr. Schnedler stated that as of June 1, the Greene Co ty Medical Society office will take over the administrat of the Springfield Dental Society.

The Greene County Bulletin recently devoted one of issues to the AMA and it is planned that there will also a special issue devoted to the MSMA and also the lo Greene County Medical Society.

Greene County is working with the Bar Association o program similar to the one Jackson County has regardin review type panel program for malpractice problems.

District #9—Dr. Cooper indicated that he has he many favorable comments since the last Annual Session much interest has been generated regarding proposed le lation covering malpractice. He stated that he definitely f that we must communicate with the physicians at the gr roots.

District #10—Dr. Hansbrough indicated that he had formal report at this time.

REPORT OF AMA DELEGATES

Dr. Peterson indicated that they have not as yet recei instructions as Delegates regarding the AMA Annual Me ing to be held in Atlantic City beginning on June 15. M souri has eight resolutions which will be submitted. Hubert Ritter is Chief Teller and Dr. Rae Froelich is on Credentials Committee. MSMA's eight resolutions are in different reference committees. Dr. Peterson indicated t if any of the Council members are planning to attend AMA meeting to please let him know. He stated that MSMA will have a caucus on Sunday and Tuesday mo ings and, also, will sponsor a hospitality suite.

Dr. McCanse asked Dr. Peterson's reaction regarding Fourth District's stand on increase in AMA dues.

Dr. Peterson indicated that the AMA has announced addition of a Department of Negotiations. However, th is no budget for it. He stated that an increase in dues is sential if the AMA is to survive. They need to hire so top-notch people and to do more work in medical educati etc. which under the present budget is not possible.

Dr. Hetlage moved that the Council instruct our dele tion to negotiate as much as practicable to make the A dues increase as low as feasible for this coming year. M tion seconded and carried by one vote.

Dr. Peterson asked if the MSMA had any reaction to regulations published by Secretary Weinberger in the *Fe eral Register* on April 14. This indicated that physicia fees under Medicare will be established on the basis of w we were paid as of Jan. 1, 1971 as modified by a cost living index. On motion of Dr. Hansbrough, duly second it was agreed that a letter should be written to Mr. We berger stating our vehement objection to this regulation.

REPORT OF THE PRESIDENT

Dr. Chandler reported that he was privileged to m with the Greater Kansas City Orthopedic Society and repo ed to them the status of the malpractice situation in M souri and what MSMI has done up to this time.

le also reported having a very enjoyable meeting with tl Clay County Medical Society.

r. Chandler indicated that he will attend the AMA eting in Atlantic City and would be happy to accept an pointment by Dr. Peterson.

LEGISLATIVE REPORT

r. Matthews indicated that there are both a Senate and H use Committee looking into the malpractice situation and t as indicated that a committee from MSMA has been ap- p ited to work with them—this committee consisting of D Chandler, McAlhany, Matthews and Clark.

r. Matthews reported on the various bills.

hese include *HB 318* (Acupuncture), which died on the H use calendar and *HB* 342 (Extension of Chiropractic) ch passed the House but, hopefully, is hung up in the S ate.

he hearings on the Chiropractic bill were good examples o omething of which we have long been aware—the po- it al nature of Chiropractors. When supporters of HB 342 w heard, 400 to 450 "mixer" Chiropractors and their w s packed the hearing room and Capitol halls. They had h r buttons and signs and, while in the Capitol, visited th r Senators and Representatives.

ist this week, when it was time for opponents of HB 342 be heard, we were requested to "make a show of t ngth" . . . and we did. Approximately 200 turned out to o ose the bill. Ironically, more than half of these were s ight" Chiropractors and Chiropractic students. It's ob- vi s that Chiropractors know their politics.

everal other *"unfavorable"* bills have died on the vine. se include the following:

B 450, which would have lengthened the Statute of L itations from the present "two years from act" to "two s from discovery." The present malpractice insurance nma helped defeat this.

B 535, which would have added a lay member to the B rd of Healing Arts, was never heard by Committee. This v probably due to the opposition similar bills relating to ot r State Boards received.

B 483, the Coordination of Insurance Benefits bill, was ated on the House floor.

B 415, which would have required drug prescriptions to ssued on special triplicate forms issued by the Division lealth, failed to clear Committee.

wo licensing bills, *SB 18* for licensure of Cardiology T nologists and *SB 432* for licensure of Ionizing Radia- i Technologists, both were held in Committee. We op- d both these on the basis that certification is the best m hod of regulation.

couple of *good bills* also are dead for this Session. se are HB 132, the Good Samaritan bill, and HB 590, w ch calls for full maternity benefits in insurance policies.

everal bills *of interest* which died along the way include following:

B 237, which would have required the Division of H lth to operate a free mobile breast cancer detection gram. There is still about $20,000 in planning funds in overall state revenue bill.

B 761, which called for the registration and certifica- of Physician Assistants.

B 274, which would have limited those who could ad- n ister anesthesia to physicians, dentists, podiatrists and e anesthetists.

B 365, a compromise measure to establish 11 regional li icts under the Division of Mental Health.

B 404, which limited clinical research on patients and ates in state institutions.

B 467, which would have eliminated the requirement that the Director of the Division of Mental Health be a physician.

HB 761, which would have provided for state loans to medical students with a forgiveness clause for practicing in areas of need.

I have already touched on the bad Chiropractic bill still barely alive, but we have several *favorable* measures approaching final decisions. These include the following:

SB 1, the Surgicenter bill, which is well up on the House calendar and should be debated early next week. This bill provides for the licensing of ambulatory surgical centers by the Division of Health.

SB 458, the only malpractice legislation introduced this Session, is near the top of the House calendar and should reach the floor this week. The bill is enabling legislation which would permit the MSMA or other associations to set up a mutual-type malpractice insurance company.

HB 107, the Anatomical Gift Act extension will be voted on by the Senate soon. The bill would allow printing of the Anatomical Gift Act on the reverse of Missouri driver's licenses.

HB 626, which would require that group hospitalization policies provide coverage for hospital treatment of alcoholism, was recently reported out of Committee and should reach the Floor.

The same applies to HB 578, which would strengthen the Child Abuse Reporting Law. Due to the involvement of $7 million in federal funds, this bill could be moved up faster.

Several other bills we have been following with interest are still in the mill. One we haven't mentioned often is SB 58, which would permit the General Assembly to rescind by concurrent resolution any administrative rule or regulation adopted by state agencies. It also would establish a Missouri Register to give notice of proposed rules and adopted rules, similar to the *Federal Register.* Other bills in good shape for final action are the following:

SB 108, which updates the Nurses Practice Act, has passed both Houses. We have worked closely with the nurses on this bill and can find no objectionable clauses.

HB 70, which would create the Health and Educational Facilities Authority, has also passed both Houses. The Authority could help finance, build or lease health and educational facilities in the state.

Two other bills will be debated soon:

HB 479, which would provide immunity to Chiropractors serving on peer review committees.

HB 642, which would lower the required age of ambulance drivers from 21 to 18.

A few bills we have been following are rather far down on the calendar and may or may not reach the floor. These include the following:

HB 305, which calls for the licensing of psychologists. We fought this bill in the past when it placed psychologists under a separate board, but this bill places them under the umbrella of the Board of Healing Arts.

HB 272 is still in a Senate Committee. This bill would require that anyone entering Chiropractic school must complete a minimum of 60 hours of pre-professional education in an accredited college.

Brief discussion followed regarding various bills. On motion, duly seconded, the Legislative Report was approved. Dr. Matthews commended staff for their efforts during this session. Chairman McAlhany expressed his personal thanks to Dr. Matthews for a job well done and stated that we are very appreciative of his efforts.

REPORT OF WOMAN'S AUXILIARY

Mrs. McPhee thanked the Council for helping to make the Auxiliary's annual meeting a great success and indicated that the Auxiliary is eager and willing to help the Association in any way they can. She stated that their major objectives are to extend the aims of MSMA and its programs for the advancement of medicine and public health. Mrs. McPhee indicated some of the major goals of the Auxiliary for the current year.

Mrs. McPhee stated that she would like consideration and approval for a proposed immunization education project. This program is designed to stimulate better understanding in Missouri regarding immunizations. There is considerable supporting data in our state regarding declining immunization levels of one- to four-year-olds and, also, a complacency among the adult population regarding immunization for themselves. The project plan is that as many Missourians as possible receive a communication from their own physician and health department containing immunization information and a small health and immunization record book. This would be a joint effort of the Woman's Auxiliary, the Missouri Division of Health and MSMA.

Mrs. McPhee reported that it is planned that early in the summer, a letter will be mailed to the MSMA membership telling them of the proposed immunization education plan and asking if they would like to participate in the project by including the approved information as a part of their October 1 statement mailing. This timing will coincide with the national designation of *October as Immunization Action Month*. Included in the letter to the membership will be a postage paid return postcard on which physician participants may indicate the number of pieces of the material needed.

It would be the responsibility of MSMA to approve the project and provide a consultant to the committee, who will review all of the materials, to inform the MSMA membership of the project and to encourage their participation and to assume the cost of one mailing and the return postcard.

Mrs. McPhee indicated that for the last several years, the Woman's Auxiliary has joined with the AMA in promoting the health education aspects of immunization. Many state associations and their auxiliaries have participated in modifications of such programs and this proposed project is designed to be a public service by the physician, the Division of Health and the Auxiliary.

Brief discussion followed regarding several aspects of the program and several questions were raised concerning the accuracy of the brochure to be included in the mailing. It was pointed out that any discrepancies would be corrected. On motion, duly seconded, it was agreed that the MSMA endorse and participate in the above stated immunization education project.

APPOINTMENT OF COUNCILOR ADVISORS TO MSMA COMMISSIONS

Dr. McAlhany appointed the following Councilors to serve as Councilor Advisors to MSMA Commissions:

Commission on Continuing Education and Health Manpower—Dr. McCanse
Commission on Public Affairs—Dr. Martin
Commission on Interspecialty Medicine—Dr. Hansbrough
Commission on Medical Economics, Third Party Medicine and Governmental Relations—Dr. Hetlage
Commission on Medical-Legal Affairs—Dr. McAlhany

REPORT OF FIELD SECRETARY

Mr. Don Wilson, MSMA Field Secretary, reported that he had now visited 82 counties in the state. He has attended 16 county medical society meetings. Mr. Wilson gave a rundown by districts on the medical societies in each district that he has visited. He stated that the subjects that physicians wanted to discuss covered a wide range of topics including professional liability insurance, medical legislat continuing medical education, AMA, PSRO, etc.

Mr. Wilson reported that a letter had been received f Mr. Larry Hughes, president of the recently formed Mis ri Foundation for Pharmaceutical Care. He stated that attended a meeting of this group. This Foundation con of two 14-man councils (a Provider Council and a C sumer Council) and an 11-man Board of Directors.

The Foundation is asking for the participation of MSMA and also is asking the MSMA to nominate a re sentative to the Provider Council. The Nurses Associat the Dental Association and the Hospital Association are being asked to name a representative to the Prov Council.

During discussion, it was suggested that the Osteopa Association should be included on this Provider Council.

Motion was made, seconded and adopted to defer ac on this until we find whether or not the Osteopathic A ciation had been asked to provide a representative on Provider Council.

Mr. Wilson stated that the MSMA is still looking into matter of obtaining a second Field Secretary.

Dr. Martin stated that you would not hear the kind of port given by Mr. Wilson at the AMA because the AM not doing field work.

Dr. Hetlage stated that we had been asked to cons the following resolution received from the Missouri Phar ceutical Association:

> WHEREAS, Pharmacists are receiving a high volume of pres tions written with illegible signature and no other identificatio the physician,
>
> *Be It Resolved*, That all physicians, hospitals and clinics inst a program wherein a rubber stamp is used to identify Doctor's nature on prescriptions or orders.

Dr. Hetlage stated that it is his understanding that use of rubber stamp was generally condemned by the J Commission on Accreditation of Hospitals and he felt proving the above resolution would set a dangerous pr dent.

Dr. Hetlage moved that the Missouri Pharmaceutical sociation be advised that (1) the honoring of a stam signature is illegal on a prescription and (2) we inter the April 29 resolution as meaning that a stamp wit printed name be used to identify the validating signat above. Motion was seconded and carried.

REMARKS OF THE DEANS

Dr. Thoma, St. Louis University, reported that const tion is underway on the new ambulatory care center. I hoped that construction can begin in June or July on learning resources center.

Dr. Noback reported that 22 students had graduated May 10. A large percentage of these students are in prin care residencies. A group of 72 students will be coming fall and this group is about equally divided between and female. Members of this group are high achievers demically.

Dr. Noback stated that a student who had been drop from the UMKC program is taking the Medical School Court. This will come up during the middle of June.

Dr. William Allen of the University of Missouri-Colun stated that Dr. White asked that he extend his apologies not being able to be at the meeting.

Dr. Allen stated that the process of selection of a D was now down to two people. It is possible that the D could be named within the next month. Dr . Allen indica that no one had as yet replaced Dr. Paul Young at the U versity and it also was pointed out that Dr. Young had as yet been replaced on the Ad Hoc Committee on Conti ing Medical Education.

NEXT COUNCIL MEETING

)r. Franklin reported that the next council meeting will b held on September 12 and 13 at the Breckenridge Motel n St. Louis. There will be golf for those who wish to play o Friday, Sepbember 12 at the Westwood Country Club b inning at 12:30 PM. There will be an Executive Council m ting from 5 PM to 7 PM on the 12th at the Breckenridge M tel followed by dinner, with the regular Council meeting to be held on Saturday, September 13. On Saturday even g, Dr. and Mrs. Franklin will host a dinner for those at ling the Council meeting.

MATTERS TO BE CONSIDERED BY COUNCIL FROM 1975 HOUSE OF DELEGATES

he following resolutions were acted upon at the 1975 use of Delegates:

#1—*Certificate of Birth*—Referred to Commission on Medical-Legal Affairs.

#2—*Patient Privacy*—Referred to the Commission on Medical Economics.

#4—*Meeting of Component Societies*—President to name Ad-Hoc Committee.

#6—*Hospital Discharge Data*—Sent to Division of Health.

#7—*Courtesy Resolution*—Referred to Legislative Committee

#8—*Courtesy Resolution*—Referred to Legislative Committee

#10—*SSA Eligibility Status*—Introduced into AMA. Sent to the Missouri Hospital Association, Missouri Osteopathic Association, Department of HEW, Regional and National Social Security Association.

#11—*Politics in VA Hospital*—Introduced into AMA. Sent to Missouri Hospital Association, Missouri Osteopathic Association, Veterans Administration.

#12—*PSRO in Government Hospitals*—Introduced into AMA. Sent to Missouri Hospital Association, Missouri Osteopathic Association, Veterans Administration, HEW.

#15—*Individual Practice Association*—Referred to Commission on Medical Economics.

#17—*PSRO*—Introduced into AMA. Sent to HEW.

#19—*Tract V Program*—Sent to State Board of Healing Arts, Deans, Admission Officers.

#20—*Fluoridation*—Referred to Legislative Committee (information).

#21—*PSRO Progress*—Material coming from AMA.

#23—*Board of Healing Arts*—Referred to Legislative Committee (information).

#24—*HMO Advertising*—Introduced into AMA.

#25—*Community Medical Directory*—Referred to Commission on Medical-Legal Affairs.

#26—*Third Party Payors*—Referred to Commission on Medical Economics.

#27—*Patient Education*—Referred to Commission on Medical Economics (information).

#28—*Physicians Assistants*—Referred to Legislative Committee (information).

#29—*Task Force Report*—Referred to Committee on Publications.

#30—*Uniform Insurance Claim Form*—Referred to Commission on Medical Economics.

#31—*Evaluation of Competency*—Referred to Commission on Continuing Education.

#32—*Payments to Surgi-Centers*—Sent to Kansas City and St. Louis Blue Cross.

#33—*Federal Manpower Legislation*—Representative Symington contacted.

#34—*Interest on Unpaid Accounts*—Referred to Commission on Medical Economics.

#36—*Law Students and Medicine*—Introduced into AMA. Referred to Commission on Medical-Legal Affairs.

#37—*Refusal of Third Party Payments*—Letter sent to General American. Referred to Commission on Medical Economics (information).

#38—*PSRO Study*—Referred to Commission on Medical Economics.

Dr. McCanse asked that a copy of *Resolution #11—Politics in VA Hospitals* and *Resolution #12—PSRO in Government Hospitals* be sent to Missouri's Congressional Delegation.

Dr. Chandler stated that under *Resolution #4—Meeting of Component Societies,* he was to appoint an ad hoc committee. This committee will consist of the following members: John Laird, St. Louis County, Chairman; Edwin K. Burford, Jr., Cape Girardeau; William B. O'Connor, St. Joseph; Michael J. Clarke, Springfield; August W. Geise, St. Louis Medical; Warren F. Wilhelm, Kansas City; R. John Torontow, Nevada; John R. Dixon, Brookfield, Richard P. Bowles, Liberty.

A motion was made, seconded and carried to accept this report.

MSMI, INC.

Mr. Cooper reported that on the state level, the following committees have been established to study the malpractice problem: (1) The Senate Select Committee will have its first hearings on June 25 and 26 at the Plaza Inn in Kansas City; (2) The Governor's Task Force on Malpractice held an organizational meeting recently. There are three or four professionals and six or seven lay people on this Task Force. Dr. McAlhany is a member of this Task Force; (3) Mr. Cooper stated that it was his understanding that a sub or ad hoc committee of Missouri's House of Representatives would be appointed to study malpractice problems.

Mr. Cooper reported that MSMI had received in excess of 500 applications for professional liability insurance and 46 policies have been issued to date. Total premiums collected amount to $91,000. Breakdown by Classes of policies issued is as follows: Class 1—22, Class 2—3, Class 3—14, Class 4—3 and Class 5—4.

Mr. Cooper stated that a full mailing on our professional liability insurance program still had not gone out to the membership due to the fact that we still have not obtained excess coverage. It is hoped that a full mailing, consisting of a brochure, application and covering letter from President Chandler, will be mailed in June.

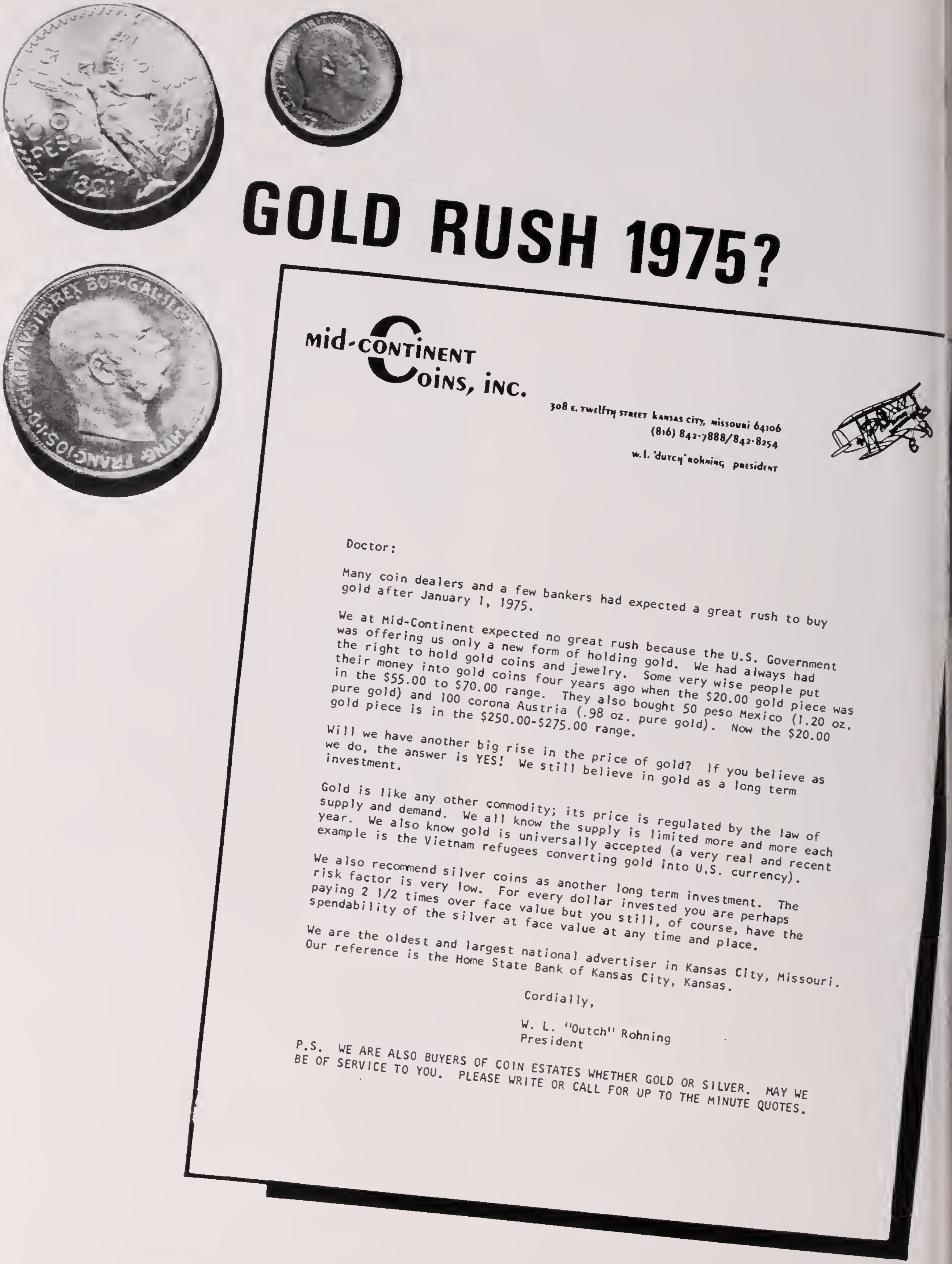
Mr. Cooper reported that the Planning Committee had recommended that a study of computer services be made. A representative of the AMA's computer program will survey the MSMA Office on June 4. Possibly MSMA will wish to participate in the AMA computer program.

Mr. Cooper stated that MSMA will sponsor a trip to Alaska, September 15-25, 1975. MSMA will also sponsor a trip to Hawaii in conjunction with the Clinical Session of the AMA in late November and early December, 1975.

PSRO DATA TASK FORCE'S UNIT DATA PROPOSAL

Dr. McCanse reported that a task force representing the five PSRO areas in Missouri studied the problem of the ever-increasing requests for hospital admission, utilization and/or discharge data. Some of these requests duplicate others but require separate handling because of the varying forms, difference in data required, etc., thus becoming a problem for those supplying the data. Soon, PSRO also will

(Continued on page 492)



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otes of interest from Here .... and There

Dr. Oscar P. Hampton, Jr., St. Louis, is one of three distinguished physician-leaders in the field of emergency medical services to be elected to honorary membership at the recent Annual Meeting of the University Association for Emergency Medical Services. He was recognized by the Association for playing "an important leadership role in developing standards for emergency medical services in the United States." In 1959, Dr. Hampton chaired the American College of Surgeon's subcommittee on Transportation of the Injured, a post he held until 1964 when he was named chairman of the Committee on Trauma for the ACS. Since 1967, he has been Assistant Director (Trauma) for the ACS and has been a leading spokesman for the creation of effective EMS programs. In 1968, he received the Surgeon's Award for Distinguished Service to Safety of the National Safety Council.

r. Wilfred E. Wooldridge, Springfield, has been invited to make a third ap-rance on the Guest Lecture Series of the New York University Medical ool in New York City on November 14. His subject will be "The Historical is of Where American Medicine Is Today and How It Got There."

Dr. James C. Sisk, St. Louis, was reelected Chairman of the St. Louis Blue Shield Board of Trustees at the annual meeting of the Plan's Voting Board in St. Louis on June 29. Other officers reelected at the meeting include **Dr. Herbert C. Wiegand**, St. Louis, first vice-chairman, and **Dr. Richard K. Danis**, St. Louis, second vice-chairman. **Dr. C. W. Chastain**, Farmington, was named to serve with the officers as a member of the Plan's Executive Committee. **Dr. Robert J. Bareis**, Marshfield, was elected as a new member of the Blue Shield Board of Trustees. Among the new members elected to the Plan's voting Board are **Dr. Robert B. Deitchman**, **Dr. John J. Kelly** and **Dr. Carol F. Williams** of St. Louis, **Dr. Benjamin N. Jolly** of Mexico, **Dr. George H. Ladyman** of Poplar Bluff and **Dr. Victor G. Occino** of Monett.

r. F. T. H'Doubler, Jr., Past-Potentate of Abou Ben Adhem Shrine Temple Springfield, was elected Imperial First Ceremonial Master at the Imperial ncil Session of the Shrine of North America by the voting representatives he 176 Shrine Temples in the United States, Canada, Mexico and the Panama al Zone. The meeting took place in Toronto, Ontario, Canada in July. If tra-on is followed, Dr. H'Doubler will eventually become the leader of the in-ational fraternal and philanthropic organization of nearly one million mem-s.

Dr. Max A. Heeb of Sikeston was elected president-elect of the Missouri Chapter of the American College of Surgeons at its Eighth Annual Meeting on June 6-7 in St. Louis. Dr. Heeb formerly was secretary-treasurer of the Chapter. Other new officers are **Dr. Paul G. Koontz, Jr.** of Kansas City, president, and **Dr. William Shieber** of St. Louis, secretary-treasurer. New Council members are **Drs. Byron J. Masterson** of Kansas City, **Ralph J. Graff** of St. Louis and **William R. Cole** of Sedalia. Each will serve a three-year term.

in Brief

A summary of AMA, medical & health news

American Medical Association / 535 North Dearborn Street / Chicago, Illinois 60610 / Phone (312) 527-1500 / TWX 910-221-0300

The AMA will form a professional liability reinsurance company. At the AMA's 12th Annual Convention, the House of Delegates voted to establish the company and make it operational as soon as possible. The facility will require the participation of five state society captive companies with a minimum of $12 million in annual premiums and AMA capitalization of $1.2 million.

Seven AMA awards were presented at the Annual Convention. Receiving the Distinguished Service Award was William R. Willard, M.D., dean of the College of Community Health Service, U. of Alabama; the Scientific Achievement Award, Rosalyn S. Yalow, Ph.D., New York, and (posthumously) Solomon A. Berson, M.D.; the Dr. Rodman E. Sheen and Thomas G. Sheen Award, Rudolph H. Kampmeier, M.D., professor emeritus, Vanderbilt U.; the Brookdale Award in Medicine, Stanley Dudrick, M.D., director of surgery, U. of Texas Medical School, Houston; and the Joseph B. Goldberger Award for Clinical Nutrition, Anada S. Prasad, M.B., chief of hematology, Wayne State U. Harry Schwartz, Ph.D., visiting professor of medical economics, Columbia U., and Leo E. Brown, retired assistant to the AMA's EVP, each received a Citation of a Layman for Distinguished Service.

The AHA asked HEW to withdraw its utilization review regulations. In a telegram to the secretary of HEW, the American Hospital Associa said that because certain sections of the regulat are keyed to the remaining sections, "any com ance with the regulations has become impossi We, therefore, respectfully request that HEW w draw the regulations in their entirety." The requ came after a preliminary injunction preventing plementation of the regulations was granted in AMA's suit. Later, a government motion for a s of the preliminary injunction was denied by three-judge panel of the Circuit Court of Appeal

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The Consumer Price Index for May shows t physicians' fees increased at a slower rate for second consecutive month. Physicians' fees r 0.6% in May, down from an 0.7% increase in A and a 1.3% increase in March. The rate of incre in hospital service charges was the same as tha physicians' fees for the second consecutive montl

The new name of the Woman's Auxiliary to AMA is the American Medical Association Au iary. The change was made at the Auxiliary's cent annual convention. It follows a bylaws cha made two years ago to provide for membership male spouses of physicians.

The 1976 AMA National Leadership Confere will be January 23-25 at the Marriott Motor Ho Chicago.

Hours worked by some interns and residents New York City will be reduced through an agr ment between the Committee of Interns and R dents and the League of Voluntary Hospitals. T agreement settled a four-day walkout by CIR wh said some of its members had worked more th 50 consecutive hours and 100 hours a week. Tw ty-one voluntary hospitals and municipal hospit which rely on the voluntary institutions for so staff were affected. Now, each hospital will be quired to form a scheduling committee. The AM backed the action calling it "a strike for better tient care." It said that when physicians work lo hours, "it is a threat to the quality of care a pati is receiving."

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From the Medical Schools

UNIVERSITY OF MISSOURI-COLUMBIA

Dr. Charles C. Lobeck, Jr. has been appointed as the new dean of the School of Medicine and will take over the duties on Sept. 1, 1975.

Dr. Lobeck

The deanship has been vacant since the resignation of *Dr. William D. Mayer* in July 1974. Provost for Health Affairs *Dr. Joseph M. White* has been serving as interim dean.

Dr. Lobeck was chosen from a field of 197 nominees for the post. The candidates were narrowed to seven deemed the most outstanding by a search committee named by Provost White. The committee made its final recommendations to the provost in March.

Dr. Lobeck has been on the faculty at the University of Wisconsin-Madison since 1958 and last year was named director of clinical affairs for University Hospitals and the University of Wisconsin Center for Health Sciences. He was chairman of the department of pediatrics from 1964 to 1974.

Dr. Lobeck received his M.D. degree in 1952 from the University of Rochester (N.Y.) School of Medicine and took his residency training in pediatrics at Strong Memorial Hospital in Rochester. He entered medical school after service in the U. S. Army Air Force in World War II.

Following his postgraduate training Dr. Lobeck was on the faculty of the School of Medicine at Rochester for three years before moving to Wisconsin in 1958.

The new dean has been prominent in professional medical societies and served as president of the Midwest Society for Pediatric Research in 1972. He also has been involved in administrative duties at the University of Wisconsin and active in medical school curriculum planning. He has served since 1968 as an elected member of the administrative advisory committee to the dean. He also was a member of the chancellor's task force committee to review the administrative structure of the medical school.

UNIVERSITY OF MISSOURI-KANSAS CITY

Two new Docents have joined the faculty of t School of Medicine. They are *Dr. Lawrence Miller* and *Dr. Robert M. Mathews.*

Dr. Miller has served as the Director of Adol cent Medicine at Children's Medical Center Dayton, Ohio since July, 1973. He previously serv a residency in Adolescent Medicine at Harva University, Boston, Mass.

Dr. Mathews has practiced general surgery in t Kansas City area for 14 years. Recently, he h served as Director of Education, Baptist Memor Hospital in Kansas City.

Joseph Timberlake, Ph.D., biochemist, has join the full-time staff of Kansas City General Hospit and Medical Center. *Fred Rommel,* Ph.D., mic biologist, will soon join the Department of Path ogy at Kansas City General Hospital and Medic Center.

Seventy-two students will begin course work th Fall at the Year 1 level of the Medical School si year program. Half of the 72 students are wom and 34 of the students come from rural counties Missouri. Fifteen of these entering students a from a non-white racial background.

In cooperation with the UMKC Conservatory Music, the School of Medicine has begun a seri of musical programs which are to be presented Theater A of the medical school building. The programs are designed to broaden the cultural e perience of students and faculty alike. The first tw musical presentations were held in May and June

ST. LOUIS UNIVERSITY

A total of 143 future physicians recited the Hi pocratic Oath at the tenth annual senior class d ceremony in May. Keynote speaker *Dr. Robert I Felix,* dean emeritus, delivered an address titl "Argonauts on the River of Change." Greeting were extended by *Dr. William Staneman, III,* a sociate dean. Salutation was by *Dr. George I Thoma,* vice-president for the Medical Center.

Sixteen of the physicians graduated with honor Among them was *Dr. Michael E. Burt,* recipient the Missouri State Medical Association award. H was a summa cum laude graduate.

A total of 56 of the recent graduates began post-
aduate training at hospitals in the St. Louis area
July 1. A total of 30 new physicians started their
ining at the St. Louis University Hospitals.

Dr. Vernon W. Fischer, assistant professor of
atomy and pathology, received the award as the
vorite teacher in the basic sciences, while *Dr.*
non Horenstein, professor of neurology and chair-
an of the department, was honored as the favorite
acher in clinical studies.

One contract and two grant awards recently
ded in the funding of cancer research, new radia-
n therapy equipment and establishment of a
y Activity Center at the St. Louis University
edical Center.

The Institute for Molecular Virology at the
hool of Medicine was the recipient of a $1,080,-
0 research contract from the National Cancer In-
tute for the coming year to study the role of
uses in human cancer and the mechanism by
ich tumor virus transform cells to malignancy.
. Maurice Green, director of the Institute and
incipal investigator, is a National Institute of
alth Lifetime Research awardee.

The Radiation Oncology Center at the St. Louis
iversity Hospitals has been awarded a $750,000
ant from the Hill Burton Program for the pur-
ase of radiation therapy equipment which will be
ated in new facilities at the Bordley Memorial
vilion now under construction. *Dr. William E.*
len, Jr., associate clinical professor of radiology,
hool of Medicine, is director of radiation therapy
the University Hospitals.

St. Louis University has entered into an agree-
ent with the New Hope Foundation of St. Louis
assist the Foundation in the development of
ng-range planning for services to the mentally
tarded and the operational funding of a Child
evelopment New Hope Day Activity Center. A
0,000 sum renewable annually was recently pre-
nted by the Foundation.

The Child Development Center of the St. Louis
iversity School of Medicine, directed by *Dr.*
lan G. Barclay, professor of psychology and ped-
rics, will cooperate with the Foundation and
th other units of the University in establishing
operational program for the Day Activity Cen-
r. It also will establish a Task Force for future
anning for the expansion program of the Foun-
tion.

Recipients of the Golden Apple award for the outstanding teacher in the basic sciences and clinical studies at the St. Louis University School of Medicine's annual awards ceremony for future physicians were Dr. Vernon Fischer and Dr. Simon Horenstein. Dr. Bonnie B. Potter, class president, made the presentations.

ASHINGTON UNIVERSITY

Jessie L. Ternberg, M.D., Ph.D., professor of
rgery and of surgery in pediatrics at Washington University School of Medicine, has been selected by the Department of Health, Education and Welfare to receive the International Women's Year Award in the field of health for Region VII. (Region VII includes Missouri, Iowa, Kansas and Nebraska.)

Chancellor William H. Danforth, M.D., said, "Dr. Jessie Ternberg has been an outstanding surgeon, teacher and medical scientist. This new award brings honor to Washington University as well as to her."

Dr. Ternberg

Congressman James W. Symington presented the award from the Federal Regional Council at a noon luncheon on June 30 in the Queeny Tower Dining Room.

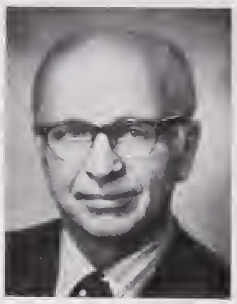
Dr. Ternberg, a member of the faculty for 18 years, has a dual appointment in the Departments of Surgery and Pediatrics. She is one of the few women in the country who practices and teaches pediatric surgery.

After an internship in medicine at Boston City Hospital, she joined the faculty of the Medical School as assistant resident in surgery in 1954. Dr. Ternberg was named assistant professor of surgery in 1962, associate professor of surgery in 1965, associate professor of pediatrics in 1971 and professor of surgery in 1971.

On July 1, 1975 Dr. Ternberg's appointment will be professor of surgery in pediatrics.

Since 1972, she has been director of the Division of Pediatric Surgery at St. Louis Children's Hospital.

William H. Daughaday, M.D., professor of medicine and co-chairman of the Division of Metabolism and Endocrinology, has received the nation's highest honor from the Endocrine Society: the Fred Conrad Koch Medal and an honorarium of $3,500.


Dr. Daughaday

Dr. Daughaday, the director of the new Diabetes Center, is the first St. Louisian to receive the Koch Award since 1947 when it went to Nobel laureates *Drs. Carl F.* and *Gerty T. Cori.* Another St. Louis scientist, *Dr. E. A. Doisy,* also was honored in 1944.

Dr. Daughaday is a pioneer in the study of growth hormone action and abnormal metabolism in diabetes. He is the author of more than 160 papers and has served as a consultant to many health agencies, including the National Institutes of Health.

In 1947, Dr. Daughaday joined the faculty as assistant resident in medicine. He was appointed instructor in medicine in 1950; assistant professor in 1951; associate professor in 1957; and professor in 1963.

A past-president of the Endocrine Society a the Central Society for Clinical Research, Daughaday is presently the editor of the *Jour of Clinical Endocrinology and Metabolism.*

The National Cancer Institute has granted $ 114,859 for support of the Washington Univers School of Medicine Cancer Center. The grant for a three-year period.

"The funds will be used in part to recruit n faculty members to help round out the Can Center staff," said *Robert E. Thach,* Ph.D., p fessor of biological chemistry and Cancer Cen associate director for basic research.

The grant also will support Cancer Center search activities already in progress, as well as t operation of the central facilities which are s under construction on the eighth floor of the M Donnell Medical Sciences Building.

The Institute granted $733,438 and Washingt University contributed $244,479 last year for c struction of the center which will have facilities tissue culture cell and virus production, and electron microscopy. Dr. Thach said the constru tion will be complete around next April.

Samuel B. Guze, M.D., Vice Chancellor for Me ical Affairs, is director of the Cancer Cent *Heschel J. Raskas,* Ph.D., associate professor pathology and of microbiology, will be the direct of the tissue culture facility.

The Council Reports

(Continued from page 485)

require this data. At present, this data system would not supply PSRO with the data it would need.

The Task Force suggests that it would be more efficient, effective and acceptable to develop a single discharge abstract and entry system which would satisfy the needs of all data users.

Dr. McCanse indicated that establishing a system of this type would require the cooperation of all interested parties in developing a simplified, unified discharge data form. This concept has been endorsed by the Jackson County Medical Society. He stated that the administration of this proposed program would be through a not-for-profit corporation. Dr. McCanse stated that this proposed program had been presented to the federal people in Kansas City and Washington. Possibly, some funding could be provided by the federal government for the establishment of the proposed program.

Dr. McCanse stated that he was asking MSMA to endorse this proposal in principle.

Dr. Peterson stated that he did not see on the proposal a place where the doctors of Missouri would be able to obtain this information about their activities without going through hospitals, third parties, PSRO, etc., and, perhaps, there should be a place in this program for doctors to obtain this information. Dr. McCanse stated that perhaps the MSMA could be included in this program on a need to know basis.

Dr. Judd stated that there are a lot of details that need looking at, but the concept is one that could be supported.

Motion was made and seconded to accept the concept principle for a Unit System for Hospital Data Providers a Users. Motion carried.

The meeting was adjourned.

* * *

EXECUTIVE SESSION

In Executive Session on Friday evening, May 30, the cision of the Council for Legal Counsel and the Trustees the MSMA Pension Program to work out a plan with M cantile Trust to become a corporate trustee which had be tentatively approved at the Council Meeting on April was further discussed. The reason for such change of trust is because of the new, complicated federal regulations a liability responsibilities under the new Federal Pension La

On motion made, duly seconded and passed, the Coun appointed Mercantile Trust Company as the corporate tru ee for the MSMA Pension Program, adopted a resolution cordingly to meet the requirements under the Pension P gram and accepted the resignations of the present thr trustees, all to take effect not less than 60 days after th actions taken on May 30.

A copy of the resolution adopted and the resignations the three trustees are on file in the Association office. T original resolution will be transmitted to Mercantile Tr Company in St. Louis.

Continuing Education Coming Events

Sept. 8	**Fourth Annual Wendell G. Scott Lecture: Gov. Christopher S. Bond** Mallinckrodt Institute of Radiology Washington U. School of Medicine, St. Louis
Sept. 26	**Symposium: Clinical Allergy for Practicing Physicians** Continuing Medical Education Erlanger Auditorium Washington U. School of Medicine, St. Louis
Sept. 26-27	**The Long Weekend: Therapeutics of Cardiac Arrhythmias and Emergency Care Workshop** MU-KC School of Medicine, K.C. Southwest Clinical Society and Academy of Health Professions MU-KC School of Medicine, Kansas City
Sept. 26-27	**Symposium: Early Management of Thermal Injuries** American Burn Association and K.U. School of Medicine Crown Center Hotel, Kansas City
Oct. 1	**Seminar: Congestive Heart Failure** The Ed Bixby Institute for Postgraduate Medical Education Research Medical Center, Kansas City
Oct. 9-10	**Seminar: Pulmonary Diseases and Infectious Diseases of the Chest** Danciger Institute for the Health Sciences Menorah Medical Center, Kansas City
Oct. 13	**City-Wide Radiology Conference: Pharmacological and Air Contrast Studies in Gastrointestinal Tract** Mallinckrodt Institute of Radiology Washington U. School of Medicine, St. Louis
Oct. 23-24	**53rd Annual Fall Clinical Conference** Kansas City Southwest Clinical Society Crown Center Hotel, Kansas City
Nov. 5-7	**Clinical Advances in Pediatrics** Postgraduate Education, Menorah Medical Center The Children's Mercy Hospital, Kansas City
Nov. 10	**City-Wide Radiology Conference: Newer Approaches in Ultrasound** Mallinckrodt Institute of Radiology Washington U. School of Medicine, St. Louis
Nov. 14-16	**Second Annual Symposium—Anesthesia for the Geriatric Patient** Dept. of Anesthesiology, Washington U. School of Medicine Marriott Motor Hotel, St. Louis

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ounty Society News

RST DISTRICT

OUNCILOR
OHN N. MARTIN, M.D., ST. JOSEPH

CHANAN COUNTY MEDICAL SOCIETY

ifty physicians and dentists attended the June 4 eting of the Buchanan County Medical Society l the Northwest Missouri Dental Society at the ila Club in St. Joseph. This was the second con- utive month in which the members of the two fessions met jointly.

The speaker for the event was Dr. Stanley S. erson, president of the American Federation of ysicians and Dentists. His topic was "Doctors' ions—They Are Here."

n his remarks, Dr. Peterson stressed the im- tance of membership and participation in the SMA and AMA, but he further noted that these ;anizations are prohibited by their charters and ir Constitution and Bylaws from any type of ion activity.

The American Federation was designed to fill need for needed negotiations with the federal ernment and other third parties in the practice medicine and dentistry. He cited several in- nces of succesful negotiation with government l insurance companies for Federation members.

Presiding jointly were the presidents of the two ieties, William B. O'Connor, M.D. and Cecil R. bright, D.D.S.

Dr. H. E. Petersen, a pediatrician in St. Joseph, roduced the speaker, Dr. Stanley S. Peterson, an ernist in Springfield.

n addition to the similarity in names, there are ny parallels in the lives and careers of the two ysicians, each of whom is prominent in his own nmunity and active in the affairs of the Missouri te Medical Association.

Both men are natives of Nebraska. Dr. H. E. tersen is a native of Fremont and remained there til leaving for medical school. Dr. Stanley S. terson was born in Grand Island and, with his rents, moved to Fremont when he was 14. Both duated from Fremont High School. They were ighbors in Fremont, but the St. Joseph physician s a few years senior to the Springfield physician d they did not meet until they had been in prac- e several years. They have been good friends for ny years by reason of their activity in the Mis- ri State Medical Association and the American dical Association.

Both physicians graduated from Midland Fremont College and both obtained their medical degrees from the University of Nebraska Medical School in Omaha. Each obtained his residency training in California: Dr. Petersen at East Bay Hospital in Oakland and Dr. Peterson at Santa Barbara Hospital.

Both physicians have spent their entire professional careers in the same community in which they began practice and both have been active in many community services. Both have held office in the Junior Chamber of Commerce, the Boy Scouts and in the United Fund. Both have served as delegates to the Missouri State Medical Association and have been Missouri delegates to the American Medical Association. Dr. Petersen has been president of the Missouri State Medical Association and Dr. Peterson has been speaker of the Association's House of Delegates.

CARL K. NESS, M.D., *Secretary*

SECOND DISTRICT

COUNCILOR
J. RUSSELL COMER, M.D., HANNIBAL

CHARITON-MACON-MONROE-RANDOLPH COUNTY MEDICAL SOCIETY

The Chariton-Macon-Monroe-Randolph County Medical Society held its monthly meeting May 7 in the library conference room at Woodland Hospital in Moberly.

The members of the Society observed a period of silent prayer in memory of a recently deceased member, Dr. Robert Young of Moberly.

Following the reading of the minutes and presentation of communications by the Secretary, Dr. R. L. Bautista, Dr. James Campbell and Dr. F. L. Barnett reported on the recent Annual Session of the Missouri State Medical Association.

The program for the evening was presented by Dr. Leonard Politte of Columbia, a cardiologist.

Dr. Politte spoke on "Coronary Artery Disease." He listed the differential diagnosis of various types of chest pain as related to the type of pain, activities, locations and etc.

He then discussed physical findings, cardiographic changes and diagnostic tests, such as the Treadmill test. He discussed the predisposing factors of coronary artery disease such as family history, cigarette smoking and metabolic changes such as hyperlipemia and increased blood pressure and the treatment and alterations of the various factors. A question and answer period followed.

Members attending the meeting were Drs. F. L. Harms, Salisbury; James Campbell and D. E. Eggleston, Macon; F. L. Barnett, Paris; P. V. Dreyer, Huntsville; Josephine Baker, C. C. Cohrs, G. R. Hudson, J. W. Fleming, T. S. Fleming and Robert Tompson, Moberly. Guests included Dr. Leonard Politte, Columbia, and Donald Wilson of the Missouri State Medical Association headquarters office.

The meeting adjourned at 9 p.m.

TENTH DISTRICT

COUNCILOR
EUGENE T. HANSBROUGH, M.D.,
POPLAR BLUFF

Mineral Area Medical Society

Robert Cudihee, M.D., Professor of Medicine at St. Louis University School of Medicine, addressed the members and guests of the Mineral Area Medical Society at the meeting on May 22. His presentation on "The Treatment of Acute Renal Failure" was unusually informative and lucid.

The business meeting was conducted by the President, Dr. Norma Farmer. Their applications having been approved by the Credentials Committee, Sioc Sien Tan, M.D. of Farmington, Nirmal Kumar Pal, M.D. of Bonne Terre and Boonfu Boonyasai, M.D. of Ironton were accepted unanimously for membership in the Mineral Area Medical Society.

Other items of business included a discussion of developments in PSRO, the addition of a large area west of Farmington to the southeast area in the newly designated "Health Service Areas" for health planning and a resume of postgraduate efforts sponsored by the Missouri Academy of Family Physicians in the Farmington area.

Members and guests present included Drs. Nieolay, Dierker, Huckstep, Keency, Chastain, Farmer, Tan, Gupta, Pal, Kiyanclar and Hoctor.

C. W. Chastain, M.D., *Secretary*

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* **Indications:** *Edema:* That associated with congestive heart failure, cirrhosis of the liver, the nephrotic syndrome; steroid-induced and idiopathic edema; edema resistant to other diuretic therapy. *Mild to moderate hypertension:* Usefulness of the triamterene component is limited to its potassium-sparing effect.

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Warnings: **Do not use dietary potassium supplements or potassium salts unless hypokalemia develops or dietary potassium intake is markedly impaired.** Enteric-coated potassium salts may cause small bowel stenosis with or without ulceration. Hyperkalemia (>5.4 mEq/L) has been reported in 4% of patients under 60 years, in 12% of patients over 60 years, and in less than 8% of patients overall. Rarely, cases have been associated with cardiac irregularities. Accordingly, check serum potassium during therapy, particularly in patients with suspected or confirmed renal insufficiency (e.g., elderly or diabetics). If hyperkalemia develops, substitute a thiazide alone. If spironolactone is used concomitantly with 'Dyazide', check serum potassium frequently—both can cause potassium retention and sometimes hyperkalemia. Two deaths have been reported in patients on such combined therapy (in one, recommended dosage was exceeded; in the other, serum electrolytes were not properly monitored). Observe patients on 'Dyazide' regularly for possible blood dyscrasias, liver damage or other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving Dyrenium (triamterene, SK&F). Rarely, leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with the thiazides. Watch for signs of impending coma in acutely ill cirrhotics. Thiazides are reported to cross the placental barrier and appear in breast milk. This may result in fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly other adverse reactions that have occurred in the adult. When used during pregnancy or in women who might bear children, weigh potential benefits against possible hazards to fetus.

Precautions: Do periodic serum electrolyte and BUN determinations. Do periodic hematologic studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in postsympathectomy patients. The following may occur: hyperuricem and gout, reversible nitrogen retention, decreasi alkali reserve with possible metabolic acidosis, hype glycemia and glycosuria (diabetic insulin requir ments may be altered), digitalis intoxication (hypokalemia). Use cautiously in surgical patient Concomitant use with antihypertensive agents ma result in an additive hypotensive effect. 'Dyazid interferes with fluorescent measurement quinidine.

Adverse Reactions: Muscle cramps, weakness, di ziness, headache, dry mouth; anaphylaxis; ras urticaria, photosensitivity, purpura, other derm tological conditions; nausea and vomiting (may i dicate electrolyte imbalance), diarrhea, constipatio other gastrointestinal disturbances. Necrotizin vasculitis, paresthesias, icterus, pancreatiti xanthopsia and, rarely, allergic pneumonitis hav occurred with thiazides alone.

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Meclizine HCl is contraindicated in individuals who have shown a previous hypersensitivity to it.

WARNINGS. Since drowsiness may, on occasion, occur with use of this drug, patients should be warned of this possibility and cautioned against driving a car or operating dangerous machinery.

Usage in Children: Clinical studies establishing safety and effectiveness in children have not been done; therefore, usage is not recommended in the pediatric age group.

Usage in Pregnancy: See "Contraindications."

ADVERSE REACTIONS. Drowsiness, dry mouth and, on rare occasions, blurred vision have been reported.

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Opinion & Dialogue

Should a specially prepared package insert be made available to patients?

Dr. Alexander M. Schmidt
Commissioner,
Food and Drug
Administration

Dr. James H. Sammons
Executive Vice President
of the American
Medical Association

The idea of a so-called patie package insert has been around f a long time. Many physicians alre use written instruction sheets to provide patients with information about the drugs they are taking. A some physicians give verbal instr tions; but in too many instances these are what I call eye-glazing e ercises. I have seen patients sit wi glazed eyes listening to a rapid-fir lecture by a hurried physician wh has 20 people out in his waiting room. These patients aren't given sufficient understanding and ther fore do not follow instructions. So think the idea of an official packa insert for patients is a good one. Perhaps we should really think of this kind of information simply as extension of drug labeling.

The benefits of patient involvemen

Many physicians may not re ize how frequently a patient obtai his drug information from Aunt Tillie or the next door neighbor. A this information is almost alway bad or irrelevant to the case at ha Furthermore, the incentive to go along with a prescribed program i slim if the only reading matter the patient receives, along with his pr scription, is a bill.

As an educator I am impress by the principle that the best way get someone to do something is to involve him in the process. So the

I think there are advantages well as some real disadvantages i a patient package insert. When yo begin to use semi-medical or med cal terms to describe complicatio or possible sequelae of disease or treatment, you may frighten the p tient—particularly since the more highly sophisticated patient is not the one who is going to read the insert. The patient who will read it is the one most susceptible to fright and confusion by the language.

On the positive side, a packa insert will probably give the patien better insight into why he is being treated the way he is, and it may give the physician a little bit more time. But it does not remove from the physician the need or obligatic to explain the insert.

Some pitfalls in the inclusion of side effects

Certainly a patient should be warned of the possibility of serious side reactions—to know what the real dangers are. But it doesn't do bit of good to indicate that a patier on oral penicillin may develop a rash, itching, or a drop in blood pressure. Or that he may faint. I think the real danger is that fright engendered by the insert may possibly outweigh the potential good.

nal purpose of drug information for the patient is to get his cooperation following a drug regimen.

Preparation and distribution of patient drug information

We would hope to amass information from physicians, medical societies, the pharmaceutical industry and centers of medical learning. The ultimate responsibility for uniform labeling must, however, rest with the Food and Drug Administration. There is nothing wrong with the agency saying, "this information is generally agreed upon and therefore it should be used," as long as our process for getting the information is sound.

Distribution of the information is a problem. In great measure it would depend on the medication in question. For example, in the case of an injectable long-acting progesterone, we would think it mandatory to issue two separate leaflets—a short one for the patient to read before getting the first shot and a long one to take home in order to make a decision about continuing therapy. In this case, the information might be put directly on the package and not removable at all. But for a medication like an antihistamine this information might be issued separately, thus giving the physician the option of distribution. This could preserve the placebo use, etc.

It is in the distribution of patient information that the pharmacist may get involved. As professionals and members of the health-care team and as a most important source of drug information to patients, pharmacists should be responsible for keeping medical and drug records on patients. It is also logical that they should distribute drug information to them.

Realistic problems must be considered

We have to expect that the introduction of an information device will also create new problems. First, how can we communicate complex and sophisticated information to people of widely divergent socioeconomic and ethnic groups? Second, what will we say? And third, how can we counteract the negative attitude of many physicians toward any outside influence or input? Hopefully the medical profession will respond by anticipating the problems and helping to solve them. Assuming we can also solve the difficulty of communicating information to diverse groups throughout the United States, our remaining task will be the inclusion of appropriate material.

What information is appropriate?

In my opinion, technical, chemical and such types of material should not be included. And there is no point in the routine listing of side effects like nausea and vomiting which seem to apply to practically all drugs, unless it is common with the drug. However, serious side effects should be listed, as should information about a medication that is potentially risky for other reasons.

Other pertinent information might consist of drug interactions, the need for laboratory follow-up, and special storage requirements. What we want to include is information that will help increase patient compliance with the therapy.

Positive aspects of patient drug information

Labeling medication for the patient would accomplish a number of good things: the patient could be on the lookout for possible serious side effects; his compliance would increase through greater understanding; the physician would be a better source of information since he would be freer to use his time more effectively; other members of the health-care team would benefit through patient understanding and cooperation; and, finally, the physician-patient relationship would probably be enhanced by the greater understanding on the part of the patient of what the physician is doing for him.

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or the doctor can remove that fear by 20 or 30 minutes of conversation.

I'm not suggesting that we withhold any information from the patient because, first of all, it would be totally dishonest and secondly, it would defeat the very purpose of the insert. I do think that a patient on the birth control pill should know about the incidence of phlebothrombosis.

If you're going to tell a patient the incidence of serious adverse reactions, then you have to tell him that a concerned medical decision was made to use a particular medication in his situation after careful consideration of the incidence of complications or side effects.

Emotionally unstable patients pose a special problem

There are patients who, because of severe emotional problems, could not handle the information contained in a patient package insert. Yet if we are going to have a package insert at all, we just can't make two inserts. I think we might simply have to tell the families of these patients to remove the insert from the package.

Legal implications of the patient package insert

Just what effect would a patient package insert have on malpractice? We could try to avoid any legal implications by pointing out that the physician has selected a particular medication because, in his professional judgment, it is the treatment of choice. For instance, you can't tell everyone taking antihistamines not to work just because a few patients develop extreme drowsiness which can lead to accidents. And what about the very small incidence of aplastic anemia rarely associated with chloramphenicol? If, based on sensitivity studies and other criteria, we decide to employ this particular antibiotic, we do so in full knowledge of this serious potential side effect. It's not a simple problem.

How do we handle an insert for medication used for a placebo effect?

With rare exceptions, physicians no longer use medications for a placebo effect. This question does raise the issue of how a patient may react to receiving a medication without a package insert.

Preparation of the package insert

The development of the insert ought to be a joint operation between physicians, the pharmaceutical industry, the A.M.A. and the F.D.A.

I view the A.M.A.'s role as a coordinator or catalyst. It is the only organization through which the profession as a whole, irrespective of specialty, can speak. It has relatively instant access to all the medical expertise in this country. And it can bring that professional expertise together to ensure a better package insert. The A.M.A. can work in conjunction with the industry that has produced the product and which is ultimately going to supply the insert.

I don't think we should rely, or expect to rely, on legislative committees and their nonprofessional staffs to make these decisions when it is perfectly within the power of the two groups to resolve the issues in the very best American tradition—without the government forcing us to do it. I think the F.D.A. has to be involved, but I'd like them to become involved because they were asked to become involved.

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Volume 72, Number 8—August, 1975

Missouri Medicine

JOURNAL OF THE MISSOURI STATE MEDICAL ASSOCIATION

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LARRY E. EDMONDS, M.S.P.H. *and*
CARL J. MARIENFELD, M.D., M.P.H., *Columbia*

rends for Total Cancer Deaths in Missouri nd the United States: 1950-1967

ETWEEN 1900 and 1965, there has been a steady in- ease in the importance of the contribution which ncer makes to the total mortality in the United ates. In 1900, cancer deaths ranked sixth among e ten leading causes of death, accounting for 7% of the total deaths. By 1965, it had risen to sec- d place and accounted for 16.3% of the total aths.[1] Although these statistical changes are due part to the decline in deaths due to the commu- cable diseases, there has been, nevertheless, a real crease in the actual numbers of deaths and the ath rates particularly for certain types of cancer.

The purpose of this paper is to describe the can- r mortality experience in Missouri for compari- n with that of the United States during the years 50 through 1967. This will represent the baseline ta for cancer death rates in Missouri. Such base- e values are essential in the planning for state- ide cancer control by the State Division of Health well as in evaluating the future effectiveness of e control program. It also will be necessary, to- ther with the newly established Missouri Cancer egistry, as a statewide cancer surveillance pro- am and for the future examination of the aller geographic units such as counties or region- planning commission areas.

ETHODOLOGY

There are a number of demographic variables hich are usually considered in any study of death tes.[2] For this presentation, we have limited the variables to those of age and sex and we are reporting for the white population only. Nonwhite death rates are being prepared and will be presented at a future date.

The mortality data were obtained from the Annual Statistical Report of the Missouri Division of Health and the U. S. Public Health Service, National Center for Health Statistics, *Vital Statistics of the United States,* 1950-1967 (Mortality, Volume II, Part A). Population figures were obtained from the United States Census Bureau's Popula-

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This comparison of total cancer mortality experience shows that Missouri and the United States are experiencing similar cancer death trends with some important differences, particularly in the rapid increase in respiratory cancer as a primary cause for death in men in Missouri. The data presented should aid materially in the planning, implementation and evaluation of the new Missouri Cancer Control Program.

The authors are from the Environmental Health Surveillance Center and the Department of Community Health and Medical Practice, University of Missouri. Mr. Edmonds is a Research Associate and Dr. Marienfeld is Director of the Surveillance Center and Professor in the Department of Community Health and Medical Practice.

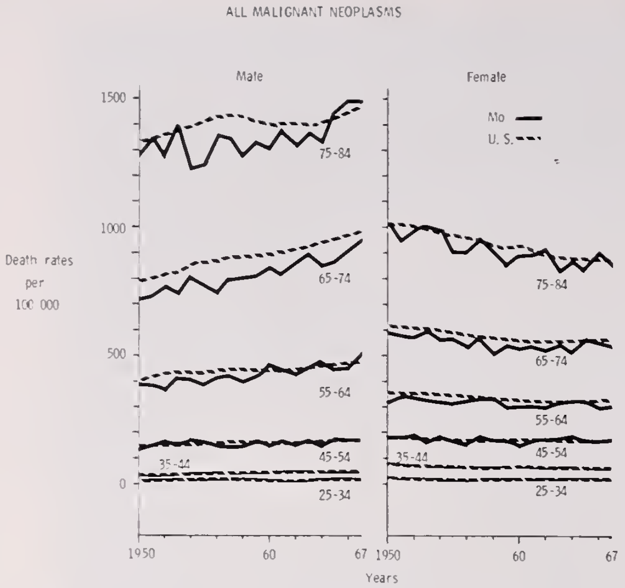

Fig. 1 Trends in death rates for all malignant neoplasms (ICD 140-205) by age and sex in Missouri and the United States, 1950 to 1967.

tion 1950, 1960 and 1970 populations and individual year estimates were made by arithmetic interpolation for the intervening years. All death rates are age-specific for ten-year age groups between the ages of 25 to 84. Death rates are expressed per 100,000 population.

Mortality Trends for All Cancer Deaths, 1950-1967

Cancer mortality rates for all malignant neoplasms (ICD 140-205)[3] by age and by sex for whites in Missouri, as contrasted to the United States rates for the years 1950-1967, are provided in Fig. 1. Fig. 1 also shows an increase in death rates for white men both in Missouri and in the United States for nearly every ten-year-age group between the ages of 25 to 84. The single exception is the 25 to 34 age group in which the very low death rates have remained unchanged. By contrast, since 1950, the white female death rates have decreased in every age group both in Missouri and in the United States. The 18-year trends in death rates, thus, show a pronounced difference in cancer mortality between the sexes with the men being primarily affected.

The United States male death rates have increased by 10% to 24% in every age group except those beyond age 34. The male death rates for Missouri have increased at an even greater rate. The Missouri cancer death rates have increased in these

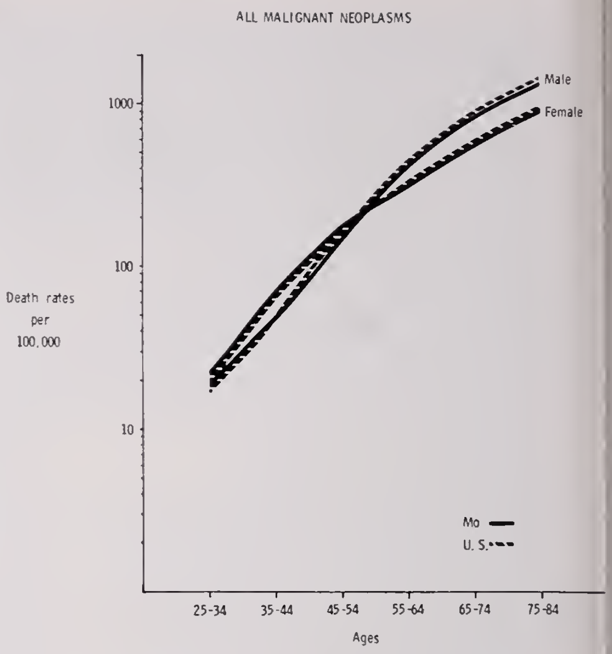

Fig. 2 Death rates for all malignant neoplasms (ICI 140-205) by age and sex in Missouri and the United State for the 18 year period 1950-1967.

age groups from 18% to 33%. While the recent rat of increase is greater in Missouri, the age specifi United States death rates, as shown in Fig. 1, re main higher than those of Missouri. The greates increase in male death rates for white men in th United States and Missouri occurs in the 55 to 7 age groups. These deaths could be categorized a "premature" or unnecessary in the terms of gen eral life expectancy.

The contrasting trend for white women show a decline in every ten-year age group between th ages of 25 to 84 for both the United States an Missouri (Fig. 1). The white female death rate declined by 6% to 21% in the various age group The smallest decline, however, occurred in the pre mature death age group from 45 to 64.

Mortality rates increase with age for both sexe with few exceptions (Fig. 2). Of interest, how ever, is the fact that total cancer death rates ar higher for women until about age 55. After ag 55, the male rates become and remain higher. Thi pattern change would appear to be primarily du to the higher female reproductive cancer deat rate in women in the earlier ages and the greatl increased respiratory cancer death rates among th older male population.

Discussion

Cancer death rate trends for the Unite

tates[1,3,4] have been studied extensively, but there less known about the individual states or regions. Missouri, the Ellis Fischel Hospital has reported number of excellent studies which were based pon patients of that hospital.[5,6] It was not possi- le, however, to relate the population of these udies to the total population of Missouri. There ight well be differences in the risk factors in Mis- uri in comparison to the total United States.

During the 1950s, the total cancer death rate for en in Missouri was below that of the United tates rate in every age group except for the ages 5 to 34. The Missouri rates, subsequently, have in- reased to such a degree that in 1967, Missouri tes had become higher than the United States tes in every age group except in that of the 65 74 age group. It is quite likely that this increase due predominantly to deaths due to respiratory ncer. This will be considered in subsequent arti- les together with possible differences in local or unty areas within Missouri.

There are a number of factors to consider as ne examines cancer death-rate trends in Missouri nd in the United States. A decline may be due to etter detection and treatment (as in uterine can- r) or to a lessened exposure to an environmental use of the disease. Conversely, an increase in the umber of deaths may be caused simply by better iagnostic techniques and, thereby, a lower thresh- ld of recognition for the disease, or it may again be due to a greater exposure to or to a new environmental cause. Air pollution and smoking may be exerting such an effect in the increasing lung cancer deaths.

If the present trends continue, cancer of the respiratory system, primarily lung cancer, will soon replace cancer of the digestive system as the primary cause of death from cancer in white men. Female death rate trends, on the other hand, show that cancer of the reproductive system continues to be the major cause of cancer deaths in women. The apparently excessive male respiratory cancer death rate increase in Missouri and the continuing high rate for cancer of the reproductive system in women, therefore, are both deserving of particular attention toward the determination of the causes and their possible prevention by the recently inaugurated Missouri Cancer Registry and statewide cancer control program.

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N. C. Hightower Jr., M.D., chairman of the Southern Medical Association's Committee on Scientific Work, has announced a series of 19 postgraduate courses scheduled for the 69th Annual Scientific Meeting of SMA to be held in Miami Beach, Fla. on November 16-19.

Courses to be featured at the Miami Beach meeting will include Basic Fetal Monitoring; Children's Orthopaedics; Gastroenterology; EKG; Morphology of Peripheral Blood Smears and Bone Marrow Sections; Diagnosis and Treatment of Platelet Disorders; Prevention and Control of Hospital-Associated Infections; Respiratory Therapy; Hypospadias, Epispadias, Peyronie's Disease, and Other Conditions Causing Penile Curvatures; Advanced Fetal Monitoring; New Develoments of Detection, Treatment, and Follow-Up of Gynecologic Malignancies; Office Management of the Infertile Couple; Hand Surgery (Part I); Hand Surgery (Part II); Pediatric Urology; Pediatric Dermatology; Dermatology for Non-Dermatologists; Functional Cast Bracing; and Disorders of Fluid, Electrolyte, and Acid-Base Balance.

All courses are approved for hour-for-hour credit in the American Medical Association Physician's Recognition Award, Category I. For more information on SMA postgraduate courses, contact the Southern Medical Association, 2601 Highland Ave. South, Birmingham, Ala. 35205.

LARRY R. ANDERSON, M.D. *a*
JAMES E. KEELER, M.D., *Kansas C*

Clear Cell Carcinoma (Mesonephroma) of the Ovary

Case Report

A 49-year-old white woman was admitted to St. Luke's Hospital on May 29, 1974 with an admission diagnosis of uterine myoma. The patient was Gravida II, Para II, living children II, and had been receiving cyclic estrogen therapy since 1971 (0.625 mg of Premarin taken orally 20 days of each month). At the age of 20, the patient had been diagnosed as having endometriosis on the basis of clinical symptoms. After a successful pregnancy at the age of 27, her symptoms disappeared. In September, 1973, the patient was seen for routine gynecological evaluation and the pelvic examination revealed a slightly enlarged uterus with a few small fibroid tumors.

The patient was next seen in mid-May, 1974 with complaints of vaginal bleeding for six weeks which, at times, required three to four pads per day. She also had noted increased frequency of urination, more profuse bleeding between Premarin cycles and an enlarging mass in the lower abdomen. Examination revealed a mass in the lower abdomen 8 cm to 10 cm in diameter. When the patient entered the hospital ten days later, the abdominal mass was approximately 20 cm in diameter. Admission laboratory values were within normal limits. No radiological studies were obtained.

At the time of laparotomy, a 25 cm cystic mass was found, originating from the left adnexal area and extending into the right parametrial region. The cyst was adherent to the sigmoid colon and parametrial tissues and was ruptured during resection. Exploration of the abdominal contents and retroperitoneal nodes revealed no primary or metastatic lesions. No ascites was pr ent. Other than rupture of the cyst, the operation w uneventful. After resection of the total mass, a froz section examination was performed. Microscopic terpretation was "probable metastatic adenocarcinor arising from a primary gastrointestinal malignanc (Figs. 1 & 2). Permanent sections revealed a clear c carcinoma with cells arranged in glandular and pap lary patterns with characteristic clear cell histolo with "hobnail" appearance in areas (Figs. 3 & 4). though the ovarian mass appeared to involve the s moid and adjacent structures, it was decided th these changes were due to inflammatory reaction a not due to spread of the malignancy. Histological e amination of the tumor mass supported this opini with an intact ovarian capsule and no invasion by m lignant cells. According to the International Federati of Gynecology and Obstetrics (FICO) guidelines 1970, the patient's malignancy was staged as 1A. T patient did well postoperatively and was discharged the ninth postoperative day. On the 18th postoperati day, the patient received the first of a six week cour of Cobalt-60 irradiation to her entire abdomen. S has received the complete course of 3,500 Rads v moving strip technique and is doing well followi therapy.

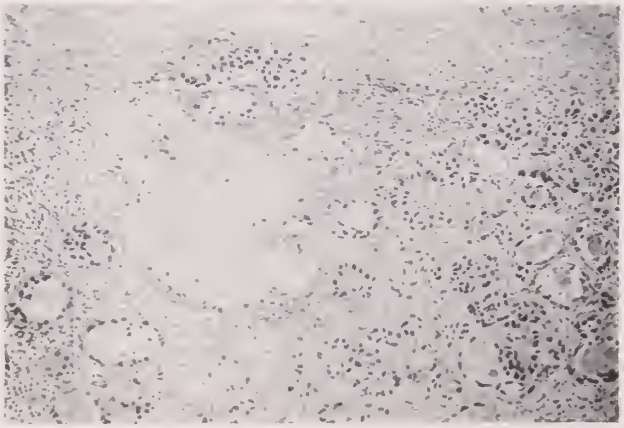

Fig. 1 Frozen section taken from tumor mass at surgery revealing nests of poorly differentiated glandular elements.

REVIEW

In 1939, Walter Schiller[1] first described ten gyn

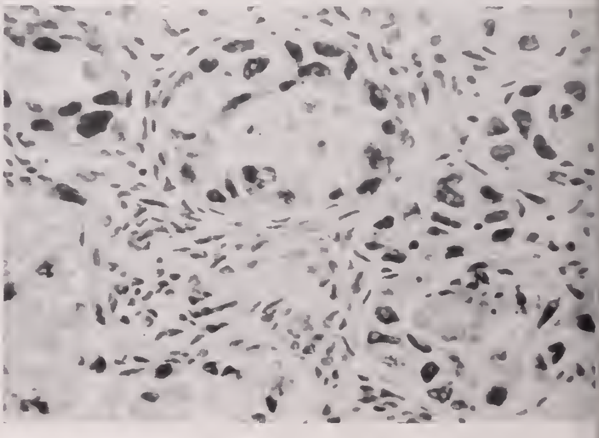

Fig. 2 High power of frozen section at surgery reve ing glandular elements interpreted as "probable metastat adenocarcinoma from a primary gastrointestinal mali nancy."

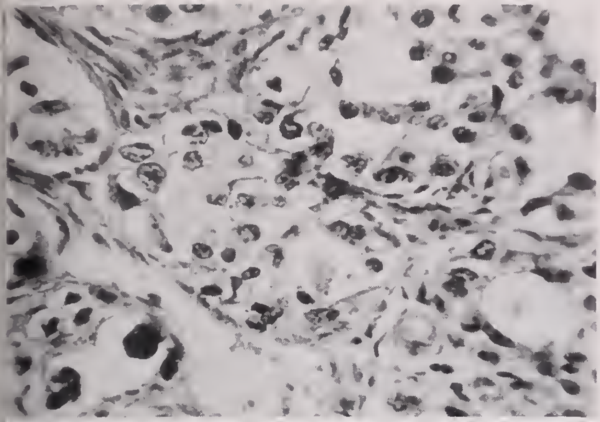

Fig. 3 High power of permanent section with charac- eristic clear cells arranged in glands with accumulation of ranular eosinophilic material in the cytoplasm in some reas.

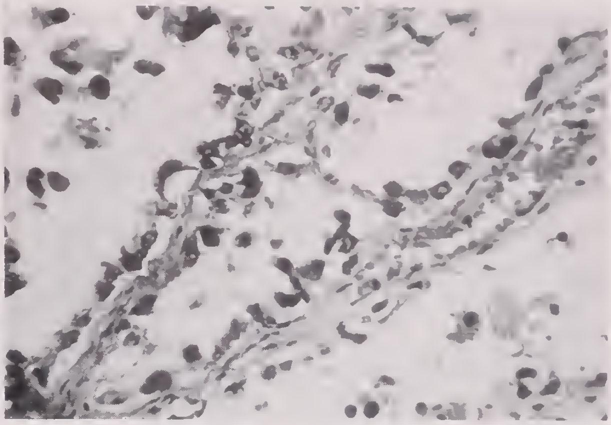

Fig. 4 High power of permanent section with "hob-nail" type cells lining the glands.

ological malignancies which he labeled as meso-ephroma ovarii. He chose this name because of haracteristic cellular components which histologi-ally appeared to be endothelial type cells lining vstic spaces. Schiller compared these cell types to ne endothelial cells lining Bowman's space in the dult glomerulus. Malignant changes in embryo-ogical remnants of the mesonephros had previous-y been identified in the cervix, vagina and par-varian tissues by other investigators. When cross ections of developing embryo revealed the pres-nce of involuting mesonephroid tissue actually in-orporated into the gonad itself, Schiller felt con-dent in labeling his new-found malignancy as mesonephroma ovarii." He did acknowledge that tumor arising in a parovarian location could in-ltrate into the gonad and become indistinguish-ble from a primary ovarian growth. He was puz-led by the rarity of tubule formation in his de-cribed cases of "mesonephroma ovarii" as the ubule formation had been characteristic in other nalignancies arising in remnants of the meso-ephros. After reviewing Schiller's original ten ases, other investigators believe that only one was true mesonephroma and that it was parovarian n origin and not a primary ovarian malignancy. Iesonephroma is an inaccurate and misleading dentification for this group of (clear cell) carci-omas. Due to its common usage and historical erspective, however, this name will probably con-inue to have wide use in identifying this group of nalignancies.

Microscopic examination of these neoplasms re-eals an admixture of large clear cells reminiscent f the hypernephroma with other cells filled with fairly granular or homogenous eosinophilic cytoplasm. These eosinophilic and clear cells frequently line widely disbursed tubular or papillary structures. Some tubular structures are lined by a single layer of flattened cells with little cytoplasm and large prominent nuclei projecting into the lumen of the tubules producing the "hob-nail" appearance.

The evolution of thinking on clear cell carcinoma of the ovary has been quite interesting and is still in a state of flux. In the classification of ovarian tumors, Novak[2] lists mesonephroma twice. It appears as an epithelial tumor of the ovary and also is listed under parovarian malignancies. Some investigators would like to see ectopic endometrial tissue listed as a third possible source of clear cell carcinoma.

In 1925, Sampson described a small group of ovarian cancers which he believed had their origin in ectopic endometrial tissue. Although an ovarian cancer could coincidentally develop adjacent to and then invade ectopic endometrial tissue, Sampson was able to present histological specimens showing definite transition from benign endometrial tissue into definite ovarian carcinoma. Additional support for this thesis is the recognized similarity between the histological appearance of some ovarian malignancies and endometrial adenocarcinomas. Especially noteworthy was the frequent finding of adenoacanthoma in these ovarian tumors with a rarity of this finding except in neoplastic endometrial tissue.

The incidence of associated pelvic endometriosis with clear cell tumors of the ovary is much higher than with other ovarian cancers. In 1966, Scully and Barlow[3] presented a paper of 17 cases of mesonephroma gathered at random and another 11 cases selected specifically because of their histo-

Most investigators now accept the theory that clear cell carcinoma is another of the primary epithelial malignancies of the ovary and has the most favorable prognosis in this group, closely followed by endometroid carcinoma. A recent case of clear cell carcinoma is presented here with a review of the current literature on the subject and previous experience with this malignancy at St. Luke's Hospital. The authors are from St. Luke's Hospital. This work was supported by St. Luke's Hospital Foundation for Medical Education and Research.

logically proven origin from endometrial cysts or endometrioid carcinoma. These two authors proposed that mesonephromas were Muellerian in origin and closely related to endometrioid tumors. Even in their series of random cases, pelvic endometriosis was found in 65%. Like Sampson, they had photomicrographs supporting their statements with some specimens showing combinations of both endometroid carcinoma and mesonephroma with occasional transitional forms identified. They proposed that these tumors be classified as clear cell tumors unless definite mesonephroid origin or histological differentiation could be identified. Although it has not been proven, they suggested a possible therapeutic role for progestational agents in the treatment of clear cell carcinomas because of the recognized histological and clinical similarities between these tumors and the endometrioid carcinoma.

In 1970, Rogers[4] and others proposed the currently leading theory that these tumors arise from the mesothelial cells covering the ovary. Although some investigators would still like to champion one theory of origin versus the other, most would agree with Fine[5] who states, "Whether these tumors arise from the pluripotential surface germinal epithelium of the ovary or displaced Muellerian derived endometrium is a moot point since both tissues are of similar origin—coelomic epithelium."

Prognosis

Apparently being of less malignant potential than other epithelial tumors of the ovary, this neoplasm rarely occurs under the age of 40 and is the most likely to be discovered prior to extensive spread, being unilateral in almost two thirds of the cases. Novak[2] states that even when confined to one ovary, the mortality approaches 50% regardless of the degree of surgery or irradiation. If extr ovarian spread is present at the time of operatio he states that mortality will be 100%.

Czernobilsky and Silverman[6] compiled the mo tality figures of many investigators and arrived a total five-year survival of 31% to 41% and a te year survival of 28% to 32%. However, when broke down to those patients with disease confined t only one ovary, a five-year survival of 80.5% and ten-year survival of 68% were obtained. These inve tigators found no significant statistical differenc in survival when comparing predominant cell typ or microscopic pattern. In other words, prognos was related primarily to staging of the malignanc at the time of diagnosis.

In contrast, Norris and Robinowitz[7] reviewed 4 cases and found a significant difference in surviva depending on cell type and microscopic patter This study showed a two and one-half fold in crease in survival in those patients whose malig nancy showed predominantly clear cell type tissue as compared to those with primarily "hob-nai type cells. They also reported a threefold increas in survival when a microscopic pattern of uniloc lar arrangement was present as compared to th multiocular or solid pattern.

St. Luke's Hospital Tumor Registry

At St. Luke's Hospital, there have been 139 pr mary ovarian malignancies since the Tumor Regis try was established in 1967. Two previous case have been diagnosed as clear cell carcinomas, gi ing this series an incidence of approximately 2 This incidence agrees with the work of Parker who found 26 clear cell carcinomas when review ing 1,192 primary ovarian malignancies at th Mayo Clinic. In comparison is the work of Kay, who found a 13.6% incidence of clear cell carcino ma in his study of 66 ovarian malignancies at th Medical College of Virginia. Both previous case at St. Luke's Hospital were in patients in their lat 40s, both were staged as 1A and both had signs o endometriosis in other pelvic organs at the time o laparotomy. During the operation, an ovarian cys was ruptured in one of these cases and the patient therefore, received 3,500 Rads of Cobalt-60 to he abdomen by moving strip technique following re covery from the operation. The other patient re ceived no postoperative therapy and both patient are now alive, doing well and clinically free of dis ease almost two years following diagnosis an therapy.

REATMENT

Primary therapy is total abdominal hysterectomy ith bilateral salpingoophorectomy, assuming an perable stage at the time of initial diagnosis. Uniteral resection of the tumor has been successful a few reported cases in which protection of fuure childbearing potential was desired. The conervative approach may be an acceptable attempt t cure due to the frequent unilateral staging of is malignancy with knowledge that prognosis is ore related to staging than therapy. It is unlikely at many surgeons will accept unilateral resection s treatment for ovarian cancer. It is preferable excise any cystic structure in toto. However, upture of malignant cysts at operation does not wer the statistical prognosis. Spontaneous rupture f malignant cysts prior to surgery does worsen rognosis.

Cobalt irradiation is recommended if residual issue is left at surgery, although statistics do not dicate any significant change in survival followg irradiation vs operative therapy alone. These tatistics are askewed as most patients with gross pread at the time of operation would be included the irradiated group.

The myriad of chemotherapeutic agents used to reat clear cell carcinoma of the ovary reflects the verall poor results. Some of the agents used have een 5-FU, cyclophosphamide, chlorambucil, thioepa, profibromycin and intraperitoneal instillation f radioactive agents, i.e., gold and phosphorus. lkeran is now probably the drug of choice in the reatment of any recurrent or metastatic primary alignancy of the ovary. Even with Alkeran, the rognosis is still pessimistic.

OMMENT

Clear cell carcinoma of the ovary is most likely a primary epithelial tumor with some well-founded support for occasional occurrence in benign ectopic endometrial tissue or endometrioid carcinoma or both. Germinal epithelium and Muellerian tissues both arise from the coelomic epithelium of the embryo which explains some of the confusion concerning the origin of clear cell tumors of the ovary.

Approximately 2% of primary ovarian malignancies are of the clear cell type. This group of malignancies has the best prognosis of the epithelial tumors of the ovary due to apparently lower malignant potential with frequent diagnosis while stage 1A. Cellular characteristics and microscopic patterns are of less importance than staging in relation to prognosis. Total resection is the treatment of choice with Cobalt-60 irradiation given with or without gross evidence of spread at the time of operation. Alkeran is reserved for palliative therapy for patients with recurrences or widespread metastatic disease or both.

With documented origin of clear cell carcinoma in benign endometrial tissue, physicians treating patients with endometriosis should be aware of possible malignant changes and follow their patients accordingly.

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The Fall Meeting of the Missouri Ophthalmological Society will be held on October 3-5 at the Lodge of the Four Seasons, Lake of the Ozarks. Guest speakers will be Drs. Arthur H. Keeney, James J. O'Rourke, Achim Wessing and Ronald E. Taven and Sen. William J. Cason. For further information, contact Carl H. Ide, M.D., Secretary-Treasurer, N309 University Medical Center, Columbia, Mo. 65201.

William M. Hart, Ph.D., M.D., was elected president of the Society at the Spring Meeting on April 19, 1975 at the Chase Park Plaza Hotel in St Louis.

PAUL F. GRMOLJEZ, M.D., JOHN E. CODD, M.D
and **GEORGE C. KAISER, M.D.,** ***St. Louis***

Traumatic Aortic Transection

Case Reports

Blunt thoracic trauma causing thoracic aortic rupture has occurred with increasing frequency. The automobile is the most frequently associated device. There have been 204 surgically treated patients reported in English literature.[1] In spite of an initial high fatality and because of improved medical evacuation, a significant number of patients will live to reach institutions where the diagnosis may be made and appropriate treatment carried out. In order to emphasize the importance of suspecting this diagnosis, the urgency of establishing the diagnosis and the need for promptness of surgical repair, we are reporting on two patients who had traumatic transection of the thoracic aorta and who were successfully managed.

Case Reports

Case # 1. Following an automobile collision, this 49-year-old man was admitted to a local hospital. He was conscious, alert and oriented, but he complained of substernal and back pain. The pulse rate was 100/min. Blood pressure in the right arm was 140/90 mm Hg; in the left arm, 150/80 mm Hg. Respiration rate was 28/min. There was bilateral periorbital ecchymosis and edema. Nasal and left zygomatic fractures were confirmed by x-ray. The chest was flail. There was tenderness over the sternum. Breath sounds were diminished at the right base posteriorly. A Grade II/VI systolic murmur was heard along the left sternal border. Abdominal examination was unremarkable. Peripheral pulses were symmetrical. There was no difference between the upper and lower extremity pulses. There was a 3 cm superficial laceration over the right knee.

Initial chest x-rays demonstrated questionable mediastinal widening, bilateral fractures of the second and third ribs at the costochondral junction and a fracture of the sternum 4 cm from the sterno-manubrial junction. The right hemidiaphragm was elevated (Fig. 1).

In spite of rib and sternal fractures and some impaired respiratory movement of the chest wall, arterial blood gases remained normal. Repeat chest x-rays showed no further changes. The patient continued to complain of back pain and pain on respiration. Blood pressure measurements in the upper extremities intermittently were slightly different. An electrocardiogram (ECG) was normal on two occasions. Because of persistent pain and the suspicion of an aortic injury, a retrograde aortogram was performed on the second hospital day. This demonstrated a laceration of the aorta just distal to the left subclavian artery (Fig. 2).

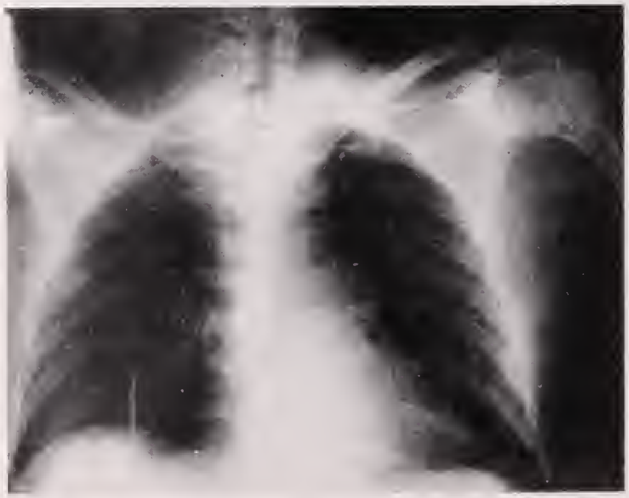

Fig. 1 AP portable admission chest x-ray of Case # 1 demonstrating minimal mediastinal widening.

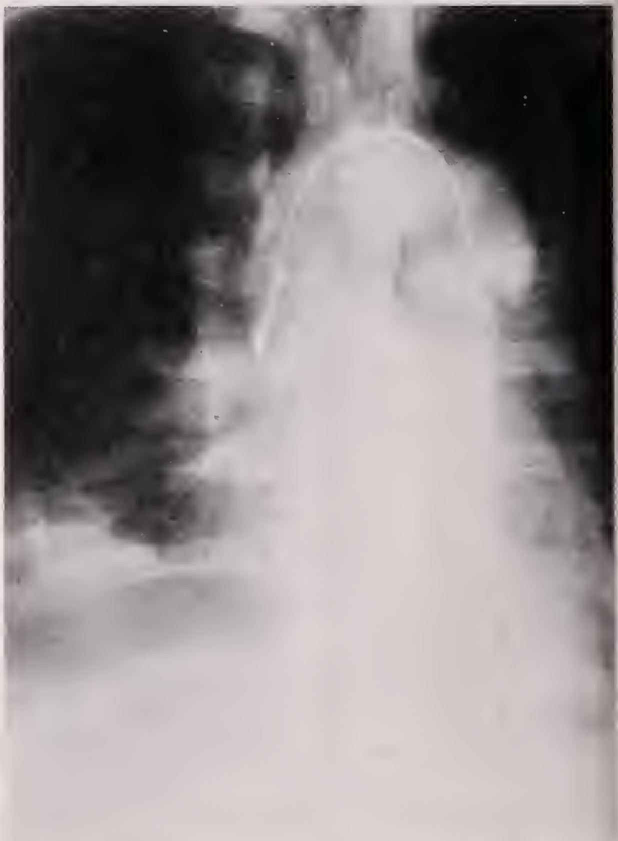

Fig. 2 Retrograde aortogram of Case # 1 demonstrating disruption of thoracic aorta distal to left subclavian artery.

he patient was transferred to St. Louis University Iospitals for operative repair.

The aorta was exposed through a left posterolateral horacotomy through the fifth intercostal space. Approximately 300 ml of sanguineous fluid was aspirated rom the pleural cavity. A large mediastinal hematoma xtended from the aortic arch to the level of the mid horacic vertebrae. After proximal control of the aorta vas obtained between the left carotid and subclavian rteries and distal control at the mid-thoracic level disal to the hematoma, a temporary plastic shunt was placed in the left subclavian artery and inserted into he distal thoracic aorta through a purse string suture. Ieparinization was not utilized. The aorta was crosslamped above and below the transection. Upon openng the hematoma, an 80% transection of the descendng aorta 3 cm distal to the left subclavian artery was dentified and repaired. The only portion of the aortic ntima and media remaining intact was that posteriorly nvolving the intercostal vessels. After debriding aortic nds, they were reapproximated with continuous fine rterial silk sutures. The cross-clamps were removed, he shunt was removed and the cannulation sites were epaired. The postoperative course was marked by pulnonary insufficiency requiring a tracheostomy and asisted ventilation. On the 16th postoperative day, an ortogram confirmed complete correction of the laceraion. Four days later, the patient underwent repair of is facial fractures. He was discharged on the 25th hosital day. The patient was readmitted to the hospital wo weeks later for evaluation of a persistent cough. A papilloma was removed at the healed tracheostomy ite by bronchoscopy, with disappearance of the cough.

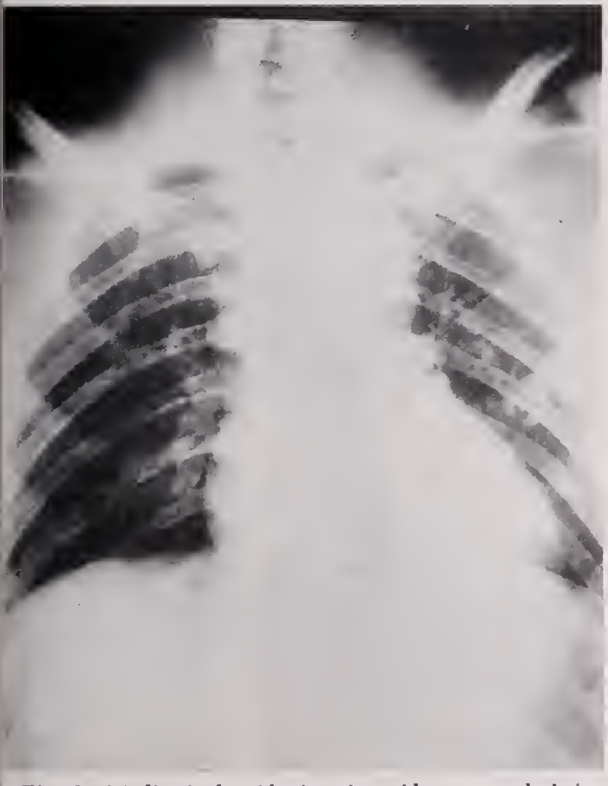

Fig. 3 Mediastinal widening is evident on admission hest x-ray of Case # 2.

Traumatic transection of the aorta is a lethal injury frequently observed in patients following automobile injuries. Management consists of recognizing it as a possibility in deceleration injuries and suspecting its presence in those patients with blunt chest trauma. Aortography is the definitive diagnostic procedure. Prompt surgical repair is mandatory.

The authors are from the Department of Surgery, St. Louis University School of Medicine. This work was supported in part by Grant HE-06312 from the U. S. Public Health Service.

The patient continues to be asymptomatic one year later, having returned to work.

Case # 2. A 30-year-old man was admitted to a local hospital after an automobile accident in which three other occupants of the car were killed. He was conscious and complained of severe pain in the thoracic spine and left wrist. Blood pressure was 180/100 mm Hg and brachial pulses were equal. A Grade III/VI holosystolic murmur was heard along the left sternal border. X-ray of the right wrist revealed a radial fracture. A widened mediastinum was obvious on chest x-ray (Fig. 3). Retrograde aortography revealed laceration of the thoracic aorta distal to the left subclavian artery (Fig. 4). The patient was transferred to St. Louis University Hospitals for definitive repair. After admission, the patient's blood pressure was lowered with antihypertensive agents and he was taken to the operating room for repair of the aortic laceration.

A left posterolateral thoracotomy exposed a large posterior mediastinal hematoma extending from just

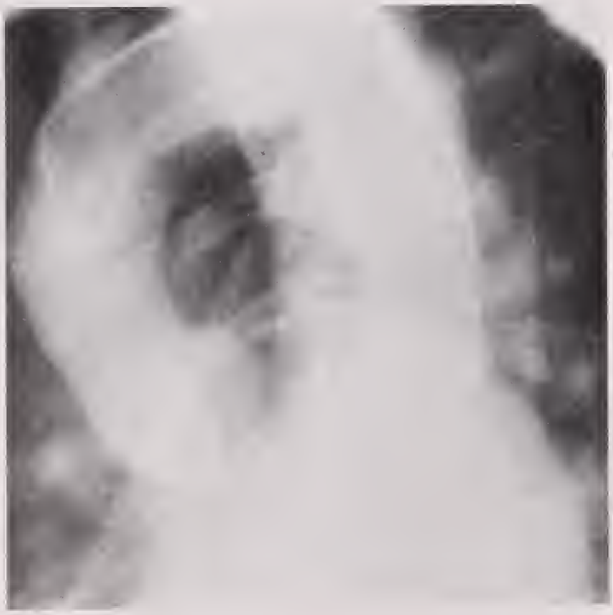

Fig. 4 Aortic laceration is evident on thoracic aortography of Case # 2.

above the left subclavian artery to the mid-thoracic aorta. There was no fluid in the pleural cavity. Control of the distal aorta, left subclavian artery and transverse aorta was obtained. The ascending and distal aorta were cannulated with a plastic shunt. The patient was not heparinized. After the aorta was cross-clamped, the hematoma was incised, exposing an 85% transverse aortic laceration 2 cm distal to the left subclavian artery. It was repaired with a continuous fine silk suture. The postoperative course was benign except for a transient atelectasis of the lower left lobe. Open reduction of the right radial fracture was performed on the seventh postoperative day, and the patient was discharged on the 14th hospital day. Prior to discharge, thoracic aortography confirmed satisfactory repair of the thoracic aorta.

Discussion

Rapid deceleration injury is the most common cause of transection of the aorta.[2] Auto accidents account for the majority of cases (84%). In a series of 218 consecutive autopsies of patients dying following automobile accidents, 16% were found to have aortic transection.[3] Approximately 15% to 20% of patients with aortic rupture will survive the first hour after injury. In addition to the initial mortality rate (80% $\leqslant$ one hour), this high rate continues: 85% $\leqslant$ 24 hours; 89% $\leqslant$ five days; and 94% $\leqslant$ two weeks.[4, 5]

Aortic transection occurs chiefly at two areas: in the ascending aorta just proximal to the innominate artery origin and in the descending aorta just distal to the origin of the left subclavian artery. These two sites are similar to those observed for origination of dissecting aneurysms of the aorta. One of the proposed etiologic factors common to both entities is fixation of the aorta at these two levels. However, in traumatic aortic transection the stress is applied externally, while in dissecting thoracic aortic aneurysm the stress is applied internally by the heart. Isolated aortic rupture occurs more frequently in the descending aorta distal to the left subclavian artery while those aortic lacerations associated with cardiac injury are usually observed in the ascending aorta. The initial high mortality rate of combined aortic and cardiac injuries usually excludes these patients from operative repair. Hence, the majority of patients with surgical repair of aortic rupture have had transection at the origin of the left subclavian artery.[4, 5]

These patients frequently have other associated injuries. Those most commonly associated are fractures of the ribs and extremities and, to a lesser degree, the pelvis, sternum and skull. Surprisingly, diaphragmatic rupture has been observed in only 5% and other intra-abdominal injuries in 10% of those patients treated surgically.[1] The severity an diversity of associated injuries often diverts atte tion from the diagnosis of traumatic aortic tra section. The signs and symptoms most commonl observed with aortic rupture are chest pain, systoli murmur, pulse differences and, to a lesser degre hypertension and dyspnea. Paraplegia, hoarsenes cough and dysphagia occur infrequently.[6]

Other than suspicion of a diagnosis followin deceleration injury and the presence of commonl associated signs and symptoms, roentgenologic findings may increase suspicion of the diagnosis. Med astinal widening is the most frequently observe finding, but it has occurred in only one-half of th patients.[1, 7, 8] Hemothorax and tracheal or esophageal distortion occur even less frequently. Mos physicians have become aware of mediastinal widening as a concomitant finding of aortic rupture However, it is important to emphasize that aorti rupture, as in one of our patients, occurs withou associated mediastinal widening on a chest x-ray i approximately 50% of the cases.

The keystone of the diagnosis of traumati aortic transection is aortography. It is the definitiv test for establishing the diagnosis and localizin the area of injury so that it can be repaired. Thi procedure is well tolerated, easily performed an essential to planning the appropriate operative approach.

The treatment is immediate operative repair The operative technique consists of direct repair as in our patients, or insertion of a prosthetic graft if the aortic ends are too distracted. Muc effort has been expended in developing technique to preserve distal organ function during thoraci aortic cross-clamping. Two current techniques ar commonly used. They are a plastic shunt from th aorta above to below the transected area[9–11] or extracorporeal circulation which usually is established by femoral artery and vein cannulation.[12] Recently, the use of these techniques has bee questioned as to efficacy in preventing complications following thoracic aortic cross-clamping.[13] Systemic heparinization required by extracorporea circulation may contribute to significant hemorrhage in other areas of severe trauma or in the retracted lung. Our preference is to avoid the use of systemic heparin and use a plastic external shunt in these patients with transection of the descending aorta.

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(Continued on page 512)

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lucoid Impaction of the Bronchi

Case Reports

1951, Shaw[1] first described a clinical entity hich he termed mucoid impaction of the bron-us. He reported a series of ten patients present-g with roentgenographic evidence of a pulmo-ry mass which was subsequently found to be col-ections of inspissated mucus in the bronchi. In ost cases, operation had been performed for spected carcinoma. Notable was the fact that all is patients suffered from either asthma (eight of n) or chronic obstructive bronchitis (two of n). The importance of clinical recognition was nphasized since the symptomatic and radiograph- presentation closely resembles several other en-ties such as neoplasm, abscess, tuberculosis and ar-riovenous malformation which carry a signifi-ntly different prognosis.

Since Shaw's original report, several authors have ported similar findings.[2–5] The relationship of ucoid impaction of the bronchus to asthma and hronic bronchitis remains predominant, but cystic brosis[6] and aspergillosis[7–9] *also have been noted* several cases. Whereas the diagnosis and treat-ent of mucoid impaction of the bronchus was itially surgical, emphasis is now being placed on edical management.

This approach can obviate an unnecessary tho-cotomy in many cases but, of course, is depen-ent on clinical and radiologic recognition of the ntity. In our institution, we have seen two exam-les of mucoid impaction of the bronchus which erve to demonstrate the characteristic features of is lesion.

ASE REPORTS

Case # 1. A 19-year-old white man was admitted to t. Luke's Hospital with the chief complaint of left hest pain. The patient had been well until approxi-nately six months prior to admission when he experi-nced an episode of severe left lower anterior chest ain. After two weeks of intermittent pain, he saw his hysician at which time a chest x-ray revealed a ho-nogenous density in the left lower lung. Following six veeks of antibiotic therapy, there was no improvement nd the lesion had increased in size. Prior to admission, he patient had occasional cough but denied fever or emoptysis. The past medical history revealed the patient had had asthma since infancy. Physical examination disclosed only decreased breath sounds over the anterolateral chest with a pleural friction rub. Laboratory evaluation showed 10,580 white blood cells per cubic millimeter with 10% eosinophils. Bacteriologic studies were negative as were acid fast smears. Fungal cultures grew Candida and Aspergillus on different specimens. All other laboratory studies were unremarkable. A radiograph of the chest showed a mass lesion in the area of the lingula which, on tomography, contained no calcium (Fig. 1). Subsequently, the patient underwent a left upper lobectomy. Examination of the pathologic specimen revealed the lingular bronchus to be ectatic and plugged with a putty-like material consisting almost exclusively of pus and fibrin. Special stains for fungi and acid fast bacilli were negative. The postoperative course was uneventful and the patient was discharged on the ninth postoperative day.

Case # 2. This 20-year-old white man entered St. Luke's Hospital for evaluation of a right upper lobe lesion demonstrated on radiographs obtained routinely prior to a dental extraction seven months earlier. The patient was asymptomatic but the lesion was noted to have progressively increased in size. Past history included only chronic hay fever. Physical examination was entirely negative. Laboratory studies were normal with a white blood cell count of 8,500; no differential count was obtained. Plain films of the chest revealed an infiltrative process in the right upper lobe with some apparent consolidation. On tomography, a smooth, branching mass density was identified and a pulmonary artery aneurysm or arteriovenous malformation was considered (Fig. 2). Percutaneous transfemoral pulmonary angiography was performed and was normal (Fig. 3), and the possibility of mucoid impaction of the bronchus was suggested. The patient underwent a diagnostic thoracotomy with resection of the right upper

Mucoid impaction of the bronchus is a relatively benign condition causing a radiographic picture readily confused with a number of more grave conditions, particularly carcinoma of the lung. When a suspicious density is seen in the chest of an asthmatic patient, an awareness of this entity and its characteristic roentgenographic appearance might prevent an unnecessary surgical resection with its concomitant risks. The authors are Staff Radiologists at St. Luke's Hospital.

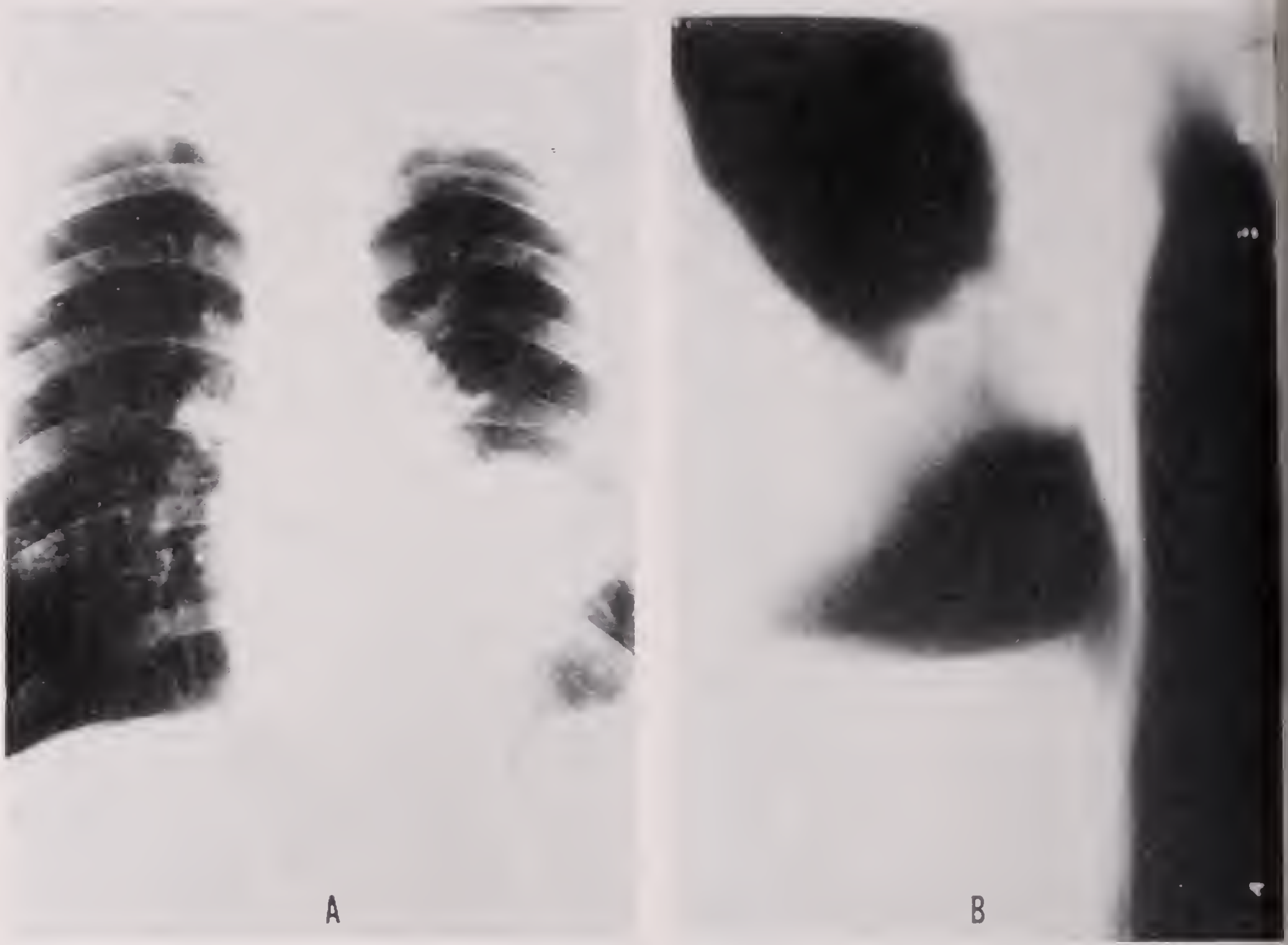

Fig. 1 (A) Plain film of the chest shows obliteration of the left heart border by a lingular infiltrate or mass. (B) Tomography demonstrates an homogenous somewhat lobulated mass abutting the left heart border.

lobe. Dissection of an upper lobe bronchial segment showed a markedly dilated ectatic bronchus filled with a rubbery viscoid material. An adjacent branch showed similar findings. Postoperatively, the patient developed a persistent pneumothorax which ultimately required reoperation thoracotomy following which he recovered uneventfully.

Discussion

Mucoid impaction of the bronchus is a syndrome characterized by the collection of masses of inspissated mucus in ectatic bronchi predominately in patients with asthma or chronic obstructive bronchitis. There is no age or sex predilection. The process involves only bronchi of the second, third and, occasionally, fourth order, thus explaining the consistent lack of distal atelectasis as due to collateral air drift via the pores of Kohn, communications of Lambert and other alveolar wall gaps. Although sometimes multiple, mucoid impaction of the bronchus is usually confined to a single area. The upper lobes are favored by approximately two to one with the right upper lobe most commonly involved. Presenting symptoms are rarely striking and primarily include cough, fever and chest pain Hemoptysis occurs in approximately 25% of cases Occasionally, patients may report expectoration of hard plugs or bronchial casts. Peripheral eosinophilia of 5% to 20% is common but also is frequently found in uncomplicated asthma.

The pathogenesis of mucoid impaction of the bronchus understandably embraces several factors. The basic substance is an abnormally viscid bronchial mucus secreted in asthmatics. Compounded by dehydration, these secretions (being less responsive to gravity) drain poorly from upper lobe bronchi and are more readily retained distal to areas of bronchial narrowing produced by asthmatic spasm or inflammatory response. The poor tussive mechanism of the upper lobes no doubt contributes to this site of predilection. The frequent association of hypersensitivity aspergillosis has been increasingly recognized. Aspergillus fumigatus may be obtained from the sputum of many patients with chronic respiratory disease, but only

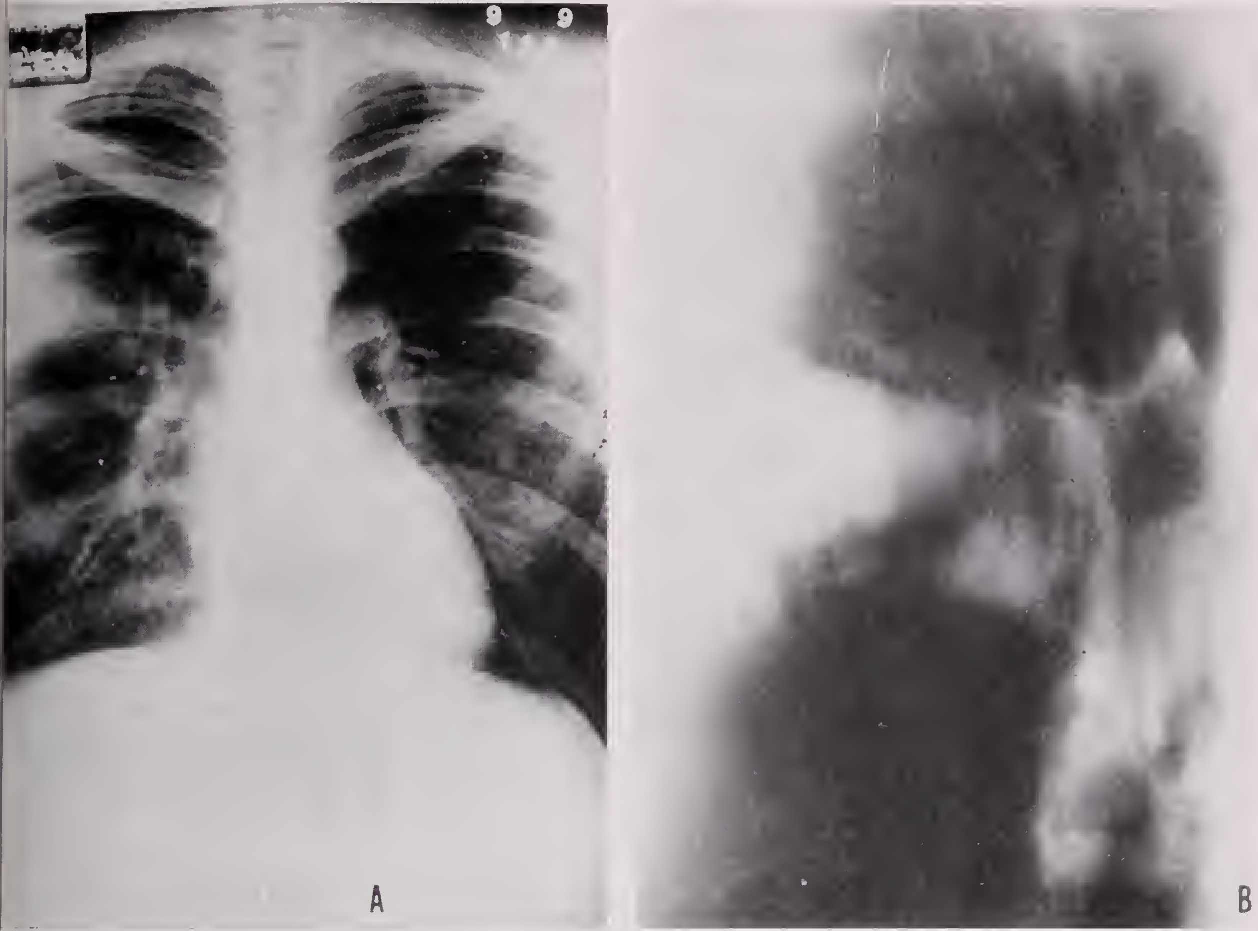

Fig. 2 There is a dense well-circumscribed infiltrate seen the upper lateral lung field on the right. (B) Tomography reveals a V-shaped branching mass with the apex directed toward the right hilum.

asthmatics is the increased frequency statistical- significant. The incidence of mucoid impaction the bronchus in several series suggests that al- rgic aspergillosis may be a major cause of this ndrome, particularly when superimposed on pre- isting asthma.

The roentgen features of mucoid impaction of e bronchus are distinctive. An oval or elliptical omogenous shadow, usually branching, is located ntrally in the lung. The density assumes a "V" "Y" configuration with the vertex directed to- ard the lung hilus. Waring has aptly termed this pearance the "mucus bronchogram." With in- lvement of several adjacent bronchi, a "cluster grapes" appearance is seen. Distal to the lesion, eumonitis is common, but atelectasis is conspicu- sly absent owing to the consistent sparing of bar bronchi and the effects of collateral air drift. ronchography in the presence of mucoid impac- on of the bronchus demonstrates complete ob- ruction of involved segments. Following resolu- on, bronchography shows a unique pattern of "proximal bronchiectasis" in which there is ectasia of the involved bronchi with normal bronchi being seen more peripherally.

Pathologically, specimens consist of masses of rubbery gray-green material. These are confined to second and third order bronchi and have not been reported in mainstem or first order bronchi.[10]

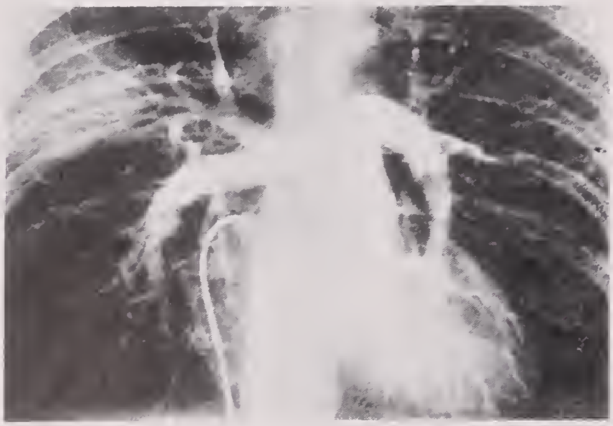

Fig. 3 Pulmonary angiography shows no abnormal vascularity associated with the right upper lobe mass.

Changes in the lung distal to the impaction include chronic pneumonitis, abscess formation and granulomatous pneumonitis.

Initially, treatment of mucoid impaction of the bronchus was surgical resection. With increasing awareness of this entity, however, the diagnosis is more often made preoperatively. Development of an adequate medical approach to the therapy could avoid many unnecessary thoracotomies. Among earlier regimens were antibiotics, bronchodilators, potassium iodide, steroids, mucolytic enzymes and surface active agents, but none of these proved to consistent value and surgical resection remained the treatment of choice for mucoid impaction. With the addition of acetylcysteine as a therapeutic tool, however, mucoid impaction of the bronchus has changed from a surgical to primarily a medical disease. Whether aerosolized or injected in solution into the bronchial tree, this agent effectively liquifies both mucus and pus without affecting fibrin or clots. Results of medical management utilizing acetylcysteine are encouraging.[11, 12]

Summary

Mucoid impaction of the bronchus is a relatively benign condition causing a radiographic pictu readily confused with a number of more gra conditions, particularly carcinoma of the lun When a suspicious density is seen in the chest an asthmatic patient, an awareness of this entit and its characteristic roentgenographic appearan might prevent an unnecessary surgical resectio with its concomitant risks.

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Traumatic Aortic Transection

(Continued from page 508)

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In Memoriam

Omar R. Sevin, M.D., 45 Briar Cliff, Rockhall, Md., a graduate of Washington University, 1913; member St. Louis Medical Society; age 85; died April 15, 1975.

Otto V. Lieb, M.D., 1114 Dauer Place, St. Louis, a graduate of St. Louis University, 1918; member St. Louis Medical Society; age 89; died May 24, 1975.

James L. O'Leary, M.D., 660 S. Kingshighwa Blvd., St. Louis, a graduate of the University of Chicago, 1931; member St. Louis Medical Societ age 70; died May 25, 1975.

B. J. Bass, M.D., 4th & Pershing, Salem, a graduate of Washington University, 1951; member Mid-Missouri Medical Society; age 50; died Jun 10, 1975.

President's Message

I have been pleased and impressed with the statewide interest being exhibited this summer in the malpractice insurance problems confronting Missouri physicians and their patients.

The Missouri Senate Select Committee on Malpractice has held hearings in Kansas City and St. Louis and is planning further hearings around the state. These hearings have been designed to explore the malpractice insurance problem, and the MSMA and individual doctors have been invited to express medicine's viewpoints. It is refreshing to have a government body ask for physicians' opinions. Lately, it seems, most governmental groups devise rules and regulations affecting the practice of medicine without prior consultation with doctors.

R. Allen Chandler

The Senate Committee has proposed four bills for pre-introduction in the 1976 Missouri Legislative Session. Although some revision is expected, the bills basically would set a $500,000 ceiling on amounts recoverable; limit the contingent fee of plaintiff attorneys to 33⅓%; shorten the statute of limitations in the case of minors; and establish medical malpractice review boards. We will have to restudy these bills when they are finalized.

In addition to the Senate Committee, a Governor's Task Force on Malpractice has been holding hearings and, it is hoped, will also provide possible solutions to today's crisis. The MSMA is represented on the Task Force.

Regardless of the merit of legislation which will emanate from these groups, it will be difficult to get it through Missouri's General Assembly without the unified assistance of many, many MSMA members and their friends. All of us must take the time and make the effort to contact our lawmakers and seek their support for medicine's position!

Physicians are not politicians. Often we feel, and justifiably so, that government doesn't really want our opinions. But now, with the Senate Committee and Task Force seeking our input, it is obvious that Missouri physicians can have a direct affect on future legislation in this area of critical importance.

Woman's Auxiliary

Mrs. William R. McPhee
President

I am happy to have Ann Balhuizen as a guest columnist this month discussing plans for participation in Immunization Action Month. She is chairman of the Auxiliary's State Health Education Committee and is the wife of a Clay County physician.

Warmly,

Mary Kay McPhee

I am grateful for the use of this space to speak to you about what we hope will be a worthwhile project.

By now, each member should have received a letter from the Missouri State Medical Association offering to send you copies of a personal medical record book and a brochure on immunization to be included with your October statements to patients. By indicating your needs on the postcard which was enclosed, you may order any quantity of either of these enclosures. This is a joint project of the Medical Association, the Woman's Auxiliary and the Missouri Division of Health. It is timed for participation in the third annual Immunization Action Month.

We hope this idea will meet with your approval and that our making this material available for use by your patients will encourage improved health care through immunization. We feel strongly that the public needs to take better advantage of the fine medical services you each offer. If your own practice does not include immunization, please do not let that prevent you from using the material.

We want to reach the widest possible number of individuals. A reminder like this, coming from your office, should influence many to get protection they have neglected. Your influence is vital. We hope we can be of help in making that influence felt even more fully through this program.

Thank you,
Ann Balhuizen
(Mrs. John Balhuizen)

LETTERS to the Editor

o the Editor:

E: "Prevalence of Polio and Measles Antibodies mong Preschool Children," MISSOURI MEDICINE, Vol. 2, No. 5, May, 1975, pp. 244-247.

The survey in Kansas City showed what appeared to e adequate levels to prevent epidemic polio but in-dequate to prevent epidemic measles. The first con-rmed measles case in Kansas City in nearly one year as reported during the first week of 1975 and, sub-quently, a total of 15 cases have been reported from e Kansas City metro area. Eight of these cases were nong preschoolers and probably resulted from contact ith school-age siblings. This outbreak might have een larger, but community immunization programs ere promptly begun.

In the effort to control measles, the state and local ealth departments now deal with each case of measles quickly as possible to prevent the development of pidemics. In some instances, index measles cases have een traced back to cases in Kansas, Nebraska and Il-nois. In other instances, cases have been traced to attered sources within the state. Quick action is need-l to prevent the spread of single measles cases and, us, avoid second and third generation cases. These ire-fighting" tactics will be necessary as long as easles antibody prevalence remains inadequate any-here in Missouri.

The Division of Health cooperates with many public d private health agencies and voluntary service oups in efforts to inform Missourians of the need for l childhood immunizations as early in life as possible. his year, the Woman's Auxiliary to the Missouri State edical Association announced plans to launch a state-ide project to educate parents regarding the immu-zation needs of their children.

In summary, since measles cases are still occurring nong inadequately or unimmunized Missourians, four ctors in the control program should be reexamined:

1) Suspect history or parental diagnosis of past infections in their children is not sufficient evidence to rule out the need for immunization. Harder evidence should be required before a child is excused from routine immunization.
2) We should expect to see measles decline very soon, considering that there have been 73.6 million doses of measles vaccine distributed nationally since 1963 with approximately one million doses administered in Missouri. On the other hand, little can be done to diminish the incidence of the various virus rashes, such as Echo and Coxsackie which mimic measles. But all rash-type illnesses should be suspect and followed up with adequate laboratory tests to assure accurate diagnosis.
3) When the immunization status of a community approaches the 90% to 95% level, the number of natural susceptibles and the previously immunized susceptibles (vaccine failures) will become approximately the same. One would then expect to see as many cases of measles occurring among the unimmunized as among the previously immunized children. This should not be alarming as vaccine efficiency is confirmed at well over 90%, but communities should be prepared to deal with this phenomenon.
4) Live measles vaccine is highly sensitive to light and heat and should be closely monitored during shipment, storage and handling to assure maximum vaccine potency.

Sincerely,
Herbert R. Domke, M.D., Dr.P.H.
Director
Missouri Division of Health

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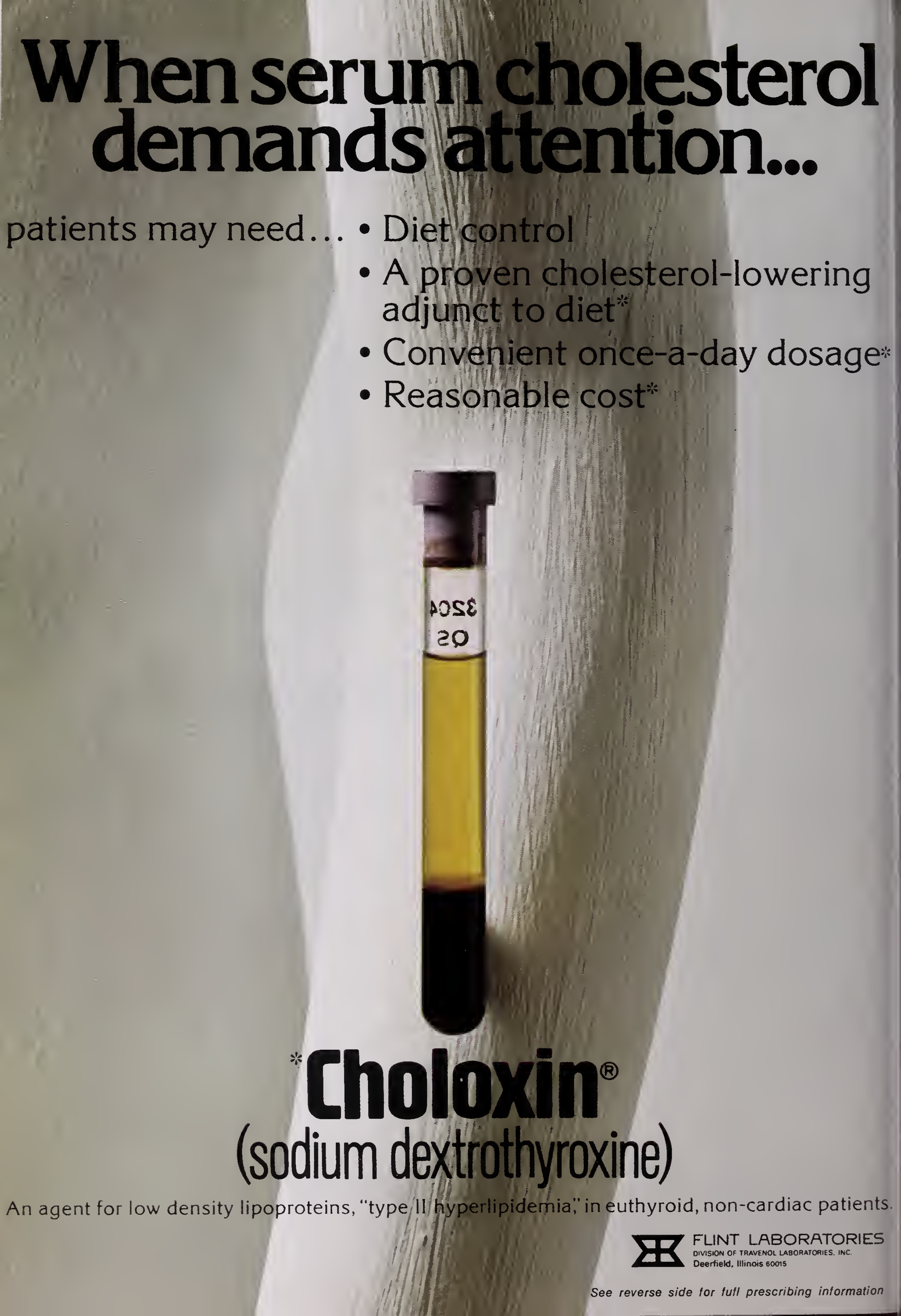

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Pediatric Hypercholesterolemic	0.05 mg./kg. body weight	0.05 mg./kg.	0.1 mg./kg. body weight	4.0 mg.
Hypothyroid Cardiac	0.5-1.0 mg.	1.0 mg.	4.0 mg.	4.0 mg.

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Description

CHOLOXIN (sodium dextrothyroxine) is the sodium salt of the dextrorotatory isomer of thyroxine. It is chemically described as D-3,5,3′,5′-tetraiodothyronine sodium salt.

Actions

The predominant effect of CHOLOXIN (sodium dextrothyroxine) is the reduction of serum cholesterol levels in hyperlipidemic patients. Beta lipoprotein and triglyceride fractions may also be reduced from previously elevated levels.

Most of the available evidence indicates that CHOLOXIN stimulates the liver to increase catabolism and excretion of cholesterol and its degradation products via the biliary route into the feces. Cholesterol synthesis is not inhibited and abnormal metabolic endproducts do not accumulate in the blood.

Indications

This is not an innocuous drug. Strict attention should be paid to the indications and contraindications.

CHOLOXIN (sodium dextrothyroxine) is an antilipidemic agent used as an adjunct to diet and other measures for the reduction of elevated serum cholesterol (low density lipoproteins) in euthyroid patients with no known evidence of organic heart disease.

The drug is also indicated in the treatment of hypothyroidism in patients with cardiac disease who cannot tolerate other types of thyroid medication.

Before prescribing, note the following: Results from a randomized clinical study have indicated a possible adverse effect when CHOLOXIN is administered to a patient receiving a digitalis preparation. There may be an additive effect. This additive effect may possibly stimulate the myocardium excessively in patients with significant myocardial impairment. CHOLOXIN dosage should not exceed 4 mg per day when the patient is receiving a digitalis preparation concomitantly. Careful monitoring of the total effect of both drugs is important.

It has not been established whether the drug-induced lowering of serum cholesterol or lipid levels has a detrimental, beneficial, or no effect on the morbidity or mortality due to atherosclerosis or coronary heart disease. Several years will be required before current investigations will yield an answer to this question.

Contraindications

The administration of CHOLOXIN (sodium dextrothyroxine) to euthyroid patients with one or more of the following conditions is contraindicated:

1. Known organic heart disease, including angina pectoris; history of myocardial infarction; cardiac arrhythmia or tachycardia, either active or in patients with demonstrated propensity for arrhythmias; rheumatic heart disease; history of congestive heart failure; and decompensated or borderline compensated cardiac status.
2. Hypertensive states (other than mild, labile systolic hypertension).
3. Advanced liver or kidney disease.
4. Pregnancy.
5. Nursing mothers.
6. History of iodism.

Warnings

CHOLOXIN (sodium dextrothyroxine) may potentiate the effects of anticoagulants on prothrombin time. Reductions of anticoagulant dosage by as much as 30% have been required in some patients. Consequently, the dosage of anticoagulants should be reduced by one-third upon initiation of CHOLOXIN therapy and the dosage subsequently readjusted on the basis of prothrombin time. The prothrombin time of patients receiving anticoagulant therapy concomitantly with CHOLOXIN therapy should be observed as frequently as necessary, but at least weekly, during the first few weeks of treatment.

In the surgical patient, it is wise to consider withdrawal of the drug two weeks prior to surgery if the use of anticoagulants during surgery is contemplated.

When CHOLOXIN is used as thyroid replacement therapy in hypothyroid patients with concomitant coronary artery disease (especially those with a history of angina pectoris or myocardial infarction) or other cardiac disease, treatment should be initiated with care. Special consideration of the dosage schedule of CHOLOXIN is required. This drug may increase the oxygen requirements of the myocardium, especially at high dosage levels. Treated subjects with coronary artery disease must be seen at frequent intervals. If aggravation of angina or increased myocardial ischemia, cardiac failure, or clinically significant arrhythmia develops during the treatment of hypothyroid patients, the dosage should be reduced or the drug discontinued.

Special consideration must be given to the dosage of other thyroid medications used concomitantly with CHOLOXIN. As with all thyroactive drugs, hypothyroid patients are more sensitive to a given dose of CHOLOXIN than euthyroid patients.

Epinephrine injection in patients with coronary artery disease may precipitate an episode of coronary insufficiency. This condition may be enhanced in patients receiving thyroid analogues. These phenomena should be kept in mind when catecholamine injections are required in sodium dextrothyroxine-treated patients with coronary artery disease.

Since the possibility of precipitating cardiac arrhythmias during surgery may be greater in patients treated with thyroid hormones, it may be wise to discontinue CHOLOXIN in euthyroid patients at least two weeks prior to an elective operation. During emergency surgery in euthyroid patients, and in surgery in hypothyroid patients in whom it may be advisable to withdraw therapy, the patients should be carefully observed.

There are reports that sodium dextrothyroxine in diabetic patients is capable of increasing blood sugar levels with a resultant increase in requirements of insulin or oral hypoglycemic agents. Special attention should be paid to parameters necessary for good control of the diabetic state in dextrothyroxine-treated subjects and to dosage requirements of insulin or other antidiabetic drugs. If sodium dextrothyroxine is later withdrawn from patients who had required an increase of insulin (or oral hypoglycemic agents) dosage during its administration, the dosage of antidiabetic drugs should be reduced and adjusted to maintain good control of the diabetic state.

When either or both impaired liver or kidney function are present, the advantages of CHOLOXIN therapy must be weighed against the possibility of deleterious results.

Usage in Women of Childbearing Age

Women of childbearing age with familial hypercholesterolemia or hyperlipemia should not be deprived of the use of this drug; it can be given to those patients exercising strict birth control procedures. Since pregnancy may occur despite the use of birth control procedures, administration of CHOLOXIN (sodium dextrothyroxine) to women of this age group should be undertaken only after weighing the possible risk to the fetus against the possible benefits to the mother. Teratogenic studies in two animal species have resulted in no abnormalities in the offspring.

Precautions

It is expected that patients on dextrothyroxine therapy will show greatly increased serum protein-bound-iodine levels. These increased serum PBI values are evidence of absorption and transport of the drug, and should NOT be interpreted as evidence of hypermetabolism; similarly, they may not be used for titrating the effective dose of CHOLOXIN (sodium dextrothyroxine). PBI values in the range of 10 to 25 mcg% in treated patients are common.

If signs or symptoms of iodism develop during CHOLOXIN therapy, the drug should be discontinued.

A few children with familial hypercholesterolemia have been treated with CHOLOXIN for periods of one year or longer with no adverse effects on growth. However, it is recommended that the drug be continued in patients in this age group only if a significant serum cholesterol-lowering effect is observed.

Adverse Reactions

The side effects attributed to dextrothyroxine therapy are, for the most part, due to increased metabolism, and may be minimized by following the recommended dosage schedule. Adverse effects are least commonly seen in euthyroid patients with no signs or symptoms of organic heart disease; the incidence of adverse effects is increased in hypothyroid patients, and is highest in those patients with organic heart disease superimposed on the hypothyroid state.

In the absence of known organic heart disease, some cardiac changes may be precipitated during sodium dextrothyroxine therapy. In addition to angina pectoris, arrhythmia consisting of extrasystoles, ectopic beats, or supraventricular tachycardia, ECG evidence of ischemic myocardial changes and increase in heart size have been observed. Myocardial infarctions, both fatal and non-fatal, have occurred, but these are not unexpected in untreated patients in the age groups studied. It is not known whether any of these infarcts were drug related.

Changes in clinical status that may be related to the metabolic action of the drug include the development of insomnia, nervousness, palpitations, tremors, loss of weight, lid lag, sweating, flushing, hyperthermia, hair loss, diuresis, and menstrual irregularities. Gastrointestinal complaints during therapy have included dyspepsia, nausea and vomiting, constipation, diarrhea, and decrease in appetite.

Other side effects reported to be associated with CHOLOXIN (sodium dextrothyroxine) therapy include the development of headache, changes in libido (increase or decrease), hoarseness, tinnitus, dizziness, peripheral edema, malaise, tiredness, visual disturbances, psychic changes, paresthesia, muscle pain, and various bizarre subjective complaints. Skin rashes, including a few which appeared to be due to iodism, and itching have been attributed to dextrothyroxine by some investigators. Gallstones have been discovered in occasional dextrothyroxine-treated patients and cholestatic jaundice has occurred in one patient, although its relationship to CHOLOXIN therapy was not established.

In several instances, the previously existing conditions of the patient appeared to continue or progress during the administration of CHOLOXIN; a worsening of peripheral vascular disease, sensorium, exophthalmos, and retinopathy have been reported.

CHOLOXIN potentiates the effects of anticoagulants, such as warfarin or Dicumarol, on prothrombin time, thus indicating a decrease in the dosage requirements of the anticoagulants. On the other hand, dosage requirements of antidiabetic drugs have been reported to be increased during dextrothyroxine therapy (see WARNINGS section).

Dosage and Administration

For **adult** euthyroid hypercholesterolemic patients, the recommended maintenance dose of CHOLOXIN (sodium dextrothyroxine) is 4 to 8 mg per day. The initial daily dose should be 1 to 2 mg to be increased in 1 to 2 mg increments at intervals of not less than one month to a maximum level of 4 to 8 mg daily, if that dosage level is indicated to effect the desired lowering of serum cholesterol.

When used as partial or complete substitution therapy for levothyroxine in hypothyroid patients with cardiac disease who cannot tolerate other types of thyroid medication, the initial daily dose should be 1 mg to be increased in 1 mg increments at intervals of not less than one month to a maximum level of 4 to 8 mg daily, preferably the lower dosage. The maximum in patients receiving digitalis therapy is 4 mg.

For **pediatric** hypercholesterolemic patients, the recommended maintenance dose of CHOLOXIN is approximately 0.1 mg per kilogram. The initial daily dosage should be approximately 0.05 mg per kilogram to be increased in up to 0.05 mg per kilogram increments at monthly intervals. The recommended maximal dose is 4 mg daily, if that dosage is indicated to effect the desired lowering of serum cholesterol.

If new signs or symptoms of cardiac disease develop during the treatment period, the drug should be withdrawn.

How Supplied

CHOLOXIN (sodium dextrothyroxine) is supplied in prescription packages of scored 1, 2, 4, and 6 mg tablets.

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New Members

Melvin N. Abend, M.D., 5724 Troost, Kansas City, has become a member of Jackson County Medical Society. Dr. Abend is a native of Kansas City, received his preliminary education at the University of Oklahoma and his M.D. degree at the University of Missouri in 1965. He specializes in plastic surgery.

H. S. Ballal, M.D., 6150 Oakland, St. Louis, has become a member of St. Louis Medical Society. Dr. Ballal is a native of India, received his preliminary education at MGM College and his M.D. degree at Bangalore Medical College in 1970. He specializes in internal medicine.

Robert E. Battmer, M.D., 4320 Wornall Rd., Kansas City, has become a member of Jackson County Medical Society. Dr. Battmer is a native of Kansas City, received his preliminary education at Central Missouri State University and his M.D. degree at the University of Missouri in 1967. He specializes in obstetrics and gynecology.

Richard M. Biery, M.D., 10th Floor, City Hall, Kansas City, has become a member of Jackson County Medical Society. Dr. Biery is a native of Alexandria, La., received his preliminary education at the University of Minnesota and his M.D. degree at the University of Minnesota in 1967. He specializes in general preventive medicine.

Lawrence J. Billy, M.D., 1325 S. Grand, St. Louis, has become a member of St. Louis Medical Society. Dr. Billy is a native of Ohio, received his preliminary education at Youngstown University and his M.D. degree at St. Louis University in 1966. He specializes in general surgery.

Nadya K. Bleisch, M.D., 524 Midvale, St. Louis, has become a member of St. Louis Medical Society. Dr. Bleisch is a native of Massachusetts, received her preliminary education at Boston University and her M.D. degree at Boston University in 1950. She specializes in pathology.

Boonfu Boonyasai, M.D., 321 S. Main, Ironton, has become a member of Mineral Area County Medical Society. Dr. Boonyasai is a native of Petburi, Thailand, received his preliminary education at Pre Medical Science College and his M.D. degree at Chiengmai Medical School in 1965. He specializes in general surgery and general medicine.

Nanthana Brahmacupta, M.D., 116 South St. Excelsior Springs, has become a member of Clay County Medical Society. Dr. Brahmacupta is a native of Bangkok, Thailand, received her preliminary education at Chulalongkorn and her M.D degree at Chulalongkorn Hospital Medical Schoo in 1965. She specializes in pediatrics.

Robert L. Carolla, M.D., 807 Stadium, Columbia, has become a member of Boone County Medical Society. Dr. Carolla is a native of Sidney, Ohio received his preliminary education at Capital University and his M.D. degree at Ohio State University in 1968. He specializes in hematology and medical oncology.

Suthon Chatkupt, M.D., 116 South Street, Excelsior Springs, has become a member of Clay County Medical Society. Dr. Chatkupt is a native of Nakornswan, Thailand, received his preliminary education at Mahidol University and his M.D. degree at Chiengmai University in 1968. He specializes in general surgery.

Robert L. Coleman, M.D., 4177 Broadway, Kansas City, has become a member of Jackson County Medical Society. Dr. Coleman is a native of Lancaster, Pa., received his preliminary education at Franklin and Marshall College and his M.D. degree at Temple University in 1966. He specializes in plastic surgery.

Barry R. Cooper, M.D., 2800 Hospital Dr., Kansas City, has become a member of Clay County Medical Society. Dr. Cooper is a native of Beloit, Kan., received his preliminary education at the University of Kansas and his M.D. degree at the University of Kansas in 1966. He specializes in diagnostic radiology.

Armando R. Favazza, M.D., 807 Stadium, Columbia, has become a member of Boone County Medical Society. Dr. Favazza is a native of New York, N. Y., received his preliminary education at Columbia University and his M.D. degree at the University of Virginia in 1966. He specializes in psychiatry.

Richard A. Fellows, M.D., 24th & Gillham Rd., Kansas City, has become a member of Jackson County Medical Society. Dr. Fellows is a native of Jackson, Mich., received his preliminary education at the University of Michigan and his M.D. degree the University of Michigan in 1966. He special- es in pediatric radiology.

John R. Goheen, M.D., 6700 Troost, Kansas ty, has become a member of Jackson County edical Society. Dr. Goheen is a native of Inde- ndence, Kan., received his preliminary education Kansas University and his M.D. degree at the niversity of Kansas in 1970. He specializes in lmonary disease.

Patrick B. Harr, M.D., Highway 71 South, Mary- lle, has become a member of Northwest Missouri edical Society. Dr. Harr is a native of Maryville, ceived his preliminary education at the Universi- of Missouri and his M.D. degree at the Univer- y of Missouri in 1969. He is in family practice.

Elizabeth M. Heimburger, M.D., 807 Stadium, olumbia, has become a member of Boone County edical Society. Dr. Heimburger is a native of lanta, Ga., received her preliminary education Georgia State University and her M.D. degree the Medical College of Georgia in 1967. She ecializes in psychiatry and family practice.

John H. Henzel, M.D., 807 Stadium, Columbia, s become a member of Boone County Medical ciety. Dr. Henzel is a native of Cleveland, Ohio, ceived his preliminary education at the Univer- y of Notre Dame and his M.D. degree at the niversity of Michigan in 1962. He specializes in neral surgery.

Mark K. Keohane, M.D., 623 Emerson Rd., St. uis, has become a member of St. Louis Medical ciety. Dr. Keohane is a native of Kansas, re- ived his preliminary education at St. Martin's llege and his M.D. degree at St. Louis University 1971. He specializes in orthopedic surgery.

Mordecai Kopperman, M.D., 701 E. 63rd, Kansas ty, has become a member of Jackson County edical Society. Dr. Kopperman is a native of St. uis, received his preliminary education at Wash- gton University and his M.D. degree at the Uni- rsity of Missouri in 1967. He specializes in diag- stic radiology.

Gamaliel G. Lotuaco, M.D., 330 W. 47th, Kansas ity, has become a member of Jackson County edical Society. Dr. Lotuaco is a native of Manila, ilippines, received his preliminary education at e University of Sto. Tomas and his M.D. degree at the University of Sto. Tomas in 1964. He specializes in plastic surgery.

George H. Myers, M.D., 6700 Troost, Kansas City, has become a member of Jackson County Medical Society. Dr. Myers is a native of Sheboygan, Wis., received his preliminary education at Rockhurst College and his M.D. degree at the University of Kansas in 1960. He specializes in urology.

Edward S. Nemec, M.D., 2870 S. Lindbergh, St. Louis, has become a member of St. Louis Medical Society. Dr. Nemec is a native of St. Louis, received his preliminary education at St. Louis University and his M.D. degree at St. Louis University in 1973. He specializes in radiology.

Olukunle Obadina, M.D., 2601 N. Whittier, St. Louis, has become a member of St. Louis Medical Society. Dr. Obadina is a native of Nigeria, received his preliminary education at St. George College and his M.D. degree at the University of Obadan in 1970. He specializes in surgery.

Nirmal K. Pal, M.D., Box 210, Hiway K, Bonne Terre, has become a member of Mineral Area County Medical Society. Dr. Pal is a native of Calcutta, India, received his preliminary education at R. G. Kar Medical College and his M.D. degree at R. G. Kar Medical College in 1961. He specializes in obstetrics and gynecology.

John C. Smith, M.D., 24th & Cherry, Kansas City, has become a member of Jackson County Medical Society. Dr. Smith is a native of Denver, Colo., received his preliminary education at the University of Oregon and his M.D. degree at the University of Oregon in 1944. He specializes in pathology.

Richard S. Sohn, M.D., 1515 Lafayette, St. Louis, has become a member of St. Louis Medical Society. Dr. Sohn is a native of New York, received his preliminary education at Brooklyn College and his M.D. degree at the University of Chicago in 1968. He specializes in neurology.

Christian H. Stehr, M.D., 609 Cherry, Springfield, has become a member of Greene County Medical Society. Dr. Stehr is a native of Fraustadt, Germany, received his preliminary education at Northwest University and his M.D. degree at Stritch School of Medicine in 1967. He specializes in anesthesiology.

Eric D. Stromberg, M.D., 6400 Prospect, Kansas City, has become a member of Jackson County Medical Society. Dr. Stromberg is a native of Morriston, N. J., received his preliminary education at Kenyon College and his M.D. degree at Washington University in 1967. He specializes in anesthesiology.

William D. Trumbower, M.D., 807 Stadium, Columbia, has become a member of Boone County Medical Society. Dr. Trumbower is a native of Chicago, Ill., received his preliminary education at the University of Missouri and his M.D. degree at the University of Missouri in 1971. He specializes in obstetrics and gynecology.

Larry G. Walker, M.D., 702 Jules, St. Joseph, has become a member of Buchanan County Medical Society. Dr. Walker is a native of Gainesville, received his preliminary education at Kansas State University and his M.D. degree at Kansas University in 1971. He specializes in diagnostic radiology.

James W. Weigel, M.D., 67th St., Columbia, has become a member of Boone County Medical Society. Dr. Weigel is a native of New York, N. Y., received his preliminary education at Canisus College and his M.D. degree at the University of Buffalo in 1951. He is in general practice.

Andrew F. Williams, M.D., 807 Stadium, Co lumbia, has become a member of Boone Count Medical Society. Dr. Williams is a native of Cair Ill., received his preliminary education at Bayl University and his M.D. degree at the Universit of Missouri in 1971. He specializes in obstetri and gynecology.

Paul A. Williams, M.D., 820 Jefferson, Fulto has become a member of Callaway County Medic Society. Dr. Williams is a native of Champaig Ill., received his preliminary education at the Un versity of Illinois and his M.D. degree at the Un versity of Missouri in 1971. He is in family prac tice.

Mitchel L. Wolf, M.D., 216 S. Kingshighway, S Louis, has become a member of St. Louis Medic Society. Dr. Wolf is a native of New York, re ceived his preliminary education at Yeshiva Un versity and his M.D. degree at Albert Einstein Co lege in 1968. He specializes in ophthalmology.

Helen Yeager, M.D., 807 Stadium, Columbia, ha become a member of Boone County Medical So ciety. Dr. Yeager is a native of Palmyra, receive her preliminary education at Central College an her M.D. degree at Washington University in 194 She specializes in pediatrics.

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Missouri Medicine in Review

FORTY YEARS AGO

Dr. Ross A. Woolsey, St. Louis, was chosen as President-Elect of the Missouri State Medical Association by the House of Delegates at the Excelsior Springs Session on May 6-10, 1935. He will serve as President-Elect during 1935-1936 and as President during 1936-1937. Dr. Woolsey is well-known by members throughout the state and is well qualified to be the leader of the medical profession in Missouri.

The American Medical Association and the Canadian Medical Association held a joint session for the first time when the two organizations convened for their annual sessions in Atlantic City on June 10-14. This was the 86th Annual Session of the AMA and the 66th Annual Session of the Canadian Medical Association. Members of both organizations took part in one program and no division was made of the two associations except for business sessions.

The Jefferson County Medical Society met in DeSoto on April 5 with Dr. John F. Rutledge of Crystal City presiding. Replies from Speaker J. G. Christy and Sen. George A. Rozier were read. The members were pleased to know that there are representatives who are in sympathy with the ideals of medicine and opposed to socialization of the profession. A letter from Dr. M. J. Bierman of St. Louis was read. He invited the members of the Society to send a representative to make a ten-minute talk at the meeting of the St. Louis Medical Society on April 30 on the subject, "Effect of the Corporate Practice of Medicine on the Practicing Physician."

TWENTY-FIVE YEARS AGO

Charles A. Brasher, M.D., Mount Vernon, w
elected president of the Missouri Chapter of t
American College of Chest Physicians at a meeti
held in St. Louis during the Annual Session of t
Missouri State Medical Association.

Milton N. Casebolt, M.D., Kansas City, was ele
ed president-elect of the Missouri Academy
General Practice at a meeting held in Springfi
on April 27. Robert C. McElvain, M.D. of
Louis was installed as president.

George W. Blankenship, M.D., Anderson, w
elected as a member of the Anderson Board
Education on April 2.

TEN YEARS AGO

On the evening of May 19, the 805th Medi
Group, Whiteman Air Force Base, served as h
to a medical meeting involving the county medi
societies in the area and the doctors' wives. Appr
imately 125 persons attended this event which h
become an annual affair. The evening's festiviti
began with an enjoyable social hour followed
an excellent dinner and program. The doctors pr
ent were privileged to hear Lt. Col. Robert Kurt
USAF, MC, Chief of Radiological Services, a
Maj. Brian S. Harrold, USAF, MC, Chief of P
thology Services, USAF Hospital, Scott AFB, Ill.

Dr. William H. Danforth has been appoint
Vice-Chancellor for Medical Affairs at Washingt
University. The appointment was effective
July 1. Dr. Danforth will succeed Dr. Carl
Moore, who will continue to serve as head of t
University's Department of Medicine. Dr. Da
forth, 38, is a graduate of Princeton Universi
and Harvard Medical School. He is an Associa
Professor of Medicine and has been a member
the staff of the Medical School since 1954. He sp
cializes in cardiology.

In addition to continuing as head of the Depa
ment of Medicine, Dr. Moore will continue f
the present to serve as President of Washingt
University School of Medicine and Associated Ho
pitals, the coordinating body which includes in a
dition to the University's five hospitals, Barna
Hospital, Barnes Hospital, Jewish Hospital and S
Louis Children's Hospital.

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Indications: Relief of anxiety and tension occurring alone or accompanying various disease states.
Contraindications: Patients with known hypersensitivity to the drug.
Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.
Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.
Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.
Usual Daily Dosage: Individualize for maximum beneficial effects. *Oral—Adults:* Mild and moderate anxiety and tension, 5 to 10 mg *t.i.d.* or *q.i.d.*; severe states, 20 or 25 mg *t.i.d.* or *q.i.d. Geriatric patients:* 5 mg *b.i.d.* to *q.i.d.* (See Precautions.)
Supplied: Librium® (chlordiazepoxide HCl) *Capsules*, 5 mg, 10 mg and 25 mg—bottles of 100 and 500; Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10; Prescription Paks of 50, available singly and in trays of 10. Libritabs® (chlordiazepoxide) *Tablets*, 5 mg, 10 mg and 25 mg—bottles of 100 and 500. With respect to clinical activity, capsules and tablets are indistinguishable.

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FOR THE PAIN

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FOR THE PATHOGENS

☐ **Effective control of susceptible pathogens** such as *E. coli, Klebsiella-Aerobacter, Staph. aureus, Proteus mirabilis* and, less frequently, *Proteus vulgaris*.

Appropriate antibacterial therapy: Up to 3 days therapy with Azo Gantrisin 4 to 6 tablets *Stat.*, then 2 tablets *q.i.d.*; then 11 days with Gantrisin (sulfisoxazole) may be considered.

AZO GANTRISIN®

(50 mg phenazopyridine HCl and 0.5 Gm sulfisoxazole)

Before prescribing, please consult complete product information, a summary of which follows.
Indications: In adults, urinary tract infections complicated by pain (primarily cystitis, pyelitis and pyelonephritis) due to susceptible organisms (usually *E. coli, Klebsiella-Aerobacter, Staphylococcus aureus, Proteus mirabilis*, and, less frequently, *Proteus vulgaris*) in the absence of obstructive uropathy or foreign bodies. *Important Note:* Carefully coordinate *in vitro* sulfonamide sensitivity tests with bacteriologic and clinical response. Add aminobenzoic acid to culture media for patients already taking sulfonamides. Increasing frequency of resistant organisms currently is a limitation of the usefulness of antibacterial agents including the sulfonamides. Blood levels should be measured in patients receiving sulfonamides for serious infections, since there may be wide variations with identical doses; 12 to 15 mg/100 ml is considered optimal for serious infections; 20 mg/100 ml should be the maximum total sulfonamide level, as adverse reactions occur more frequently above this level.
Contraindications: Children below age 12; sulfonamide hypersensitivity; pregnancy at term and during nursing period. Contraindicated in glomerulonephritis, severe hepatitis, uremia, and pyelonephritis of pregnancy with gastrointestinal disturbances, because of phenazopyridine HCl component.
Warnings: Safe use in pregnancy has not been established. Teratogenicity potential has not been thoroughly investigated. Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been reported; clinical signs such as sore throat, fever, pallor, purpura or jaundice may be early indications of serious blood disorders. Complete blood counts and urinalysis with careful microscopic examination should be performed frequently during sulfonamide therapy.
Precautions: Use with caution in patients with impaired renal or hepatic function, severe allergy, bronchial asthma and in glucose-6-phosphate dehydrogenase-deficient individuals. In the latter, hemolysis may occur. Maintain adequate fluid intake to prevent crystalluria and stone formation.
Adverse Reactions: *Blood dyscrasias:* Agranulocytosis, aplastic anemia, thrombocytopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. *Allergic reactions:* Erythema multiforme (Stevens-Johnson syndrome), skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. *Gastrointestinal reactions:* Nausea, emesis, abdominal pains, hepatitis, diarrhea, anorexia, pancreatitis and stomatitis. *C.N.S. reactions:* Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo and insomnia. *Miscellaneous reactions:* Drug fever, chills, toxic nephrosis with oliguria and anuria, polyarteritis nodosa and L.E. phenomenon. Du to certain chemical similarities with some goitr gens, diuretics (acetazolamide and thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter productio diuresis and hypoglycemia. Cross-sensitivity with these agents may exist.
Dosage: Usual adult dosage for acute, painful phase of urinary tract infections is 4 to 6 tablet initially, then 2 tablets four times daily for up t 3 days. If pain persists, causes other than infe tion should be sought. After relief of pain has been obtained, continued treatment of the infe tion with Gantrisin (sulfisoxazole) may be considered.
Note: Patients should be told that the orange-red dye (phenazopyridine HCl) will color the urine soon after ingestion.
How Supplied: Tablets, each containing 0.5 sulfisoxazole and 50 mg phenazopyridine HCl —bottles of 100 and 500.

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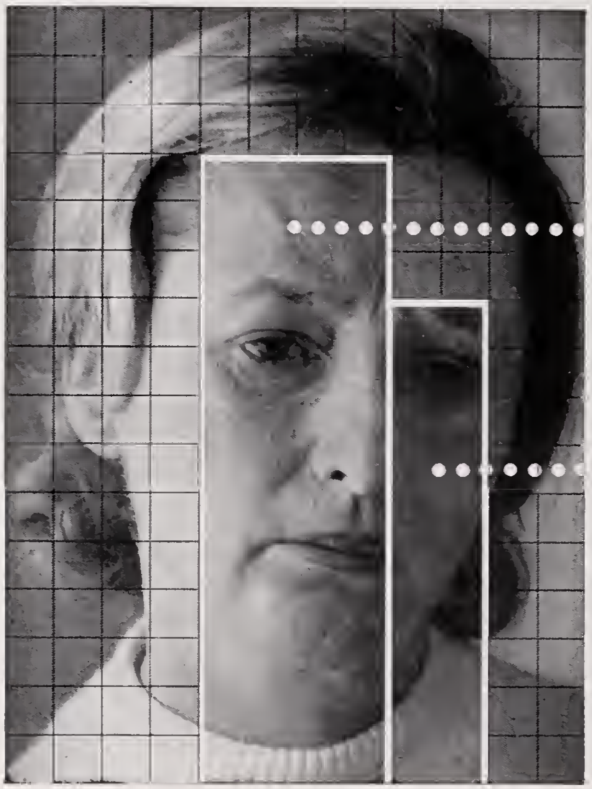
Predominant psychoneurotic anxiety
Associated depressive symptoms

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive dis-
orders, possibility of increase in frec
and/or severity of grand mal seizure
require increased dosage of standar
convulsant medication; abrupt witho
may be associated with temporary ir
crease in frequency and/or severity
seizures. Advise against simultaneo
gestion of alcohol and other CNS de
sants. Withdrawal symptoms (simila
those with barbiturates and alcohol)
occurred following abrupt discontin
(convulsions, tremor, abdominal an
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addiction-prone individuals under c

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anxiety, is often accom-
by depressive symptom-
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sociated with it are also
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re are other advan-
using Valium for the
ment of psychoneu-
xiety with secondary
ve symptoms: the
herapeutic effect of
is pronounced and
his means that im-
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in the patient within a few days rather than in a week or two, although it may take longer in some patients. In addition, Valium (diazepam) is generally well tolerated; as with most CNS-acting agents, caution patients against hazardous occupations requiring complete mental alertness.

Also, because the psychoneurotic patient's symptoms are often intensified at bedtime, Valium can offer an additional benefit. An *h.s.* dose added to the *b.i.d.* or *t.i.d.* treatment regimen can relieve the excessive anxiety and associated depressive symptoms and thus encourage a more restful night's sleep.

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anxiety states
with associated
depressive symptoms

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pharmacology of agents em-
rugs such as phenothiazines,
, barbiturates, MAO inhibitors
antidepressants may potentiate
Usual precautions indicated in
everely depressed, or with latent
n, or with suicidal tendencies.

Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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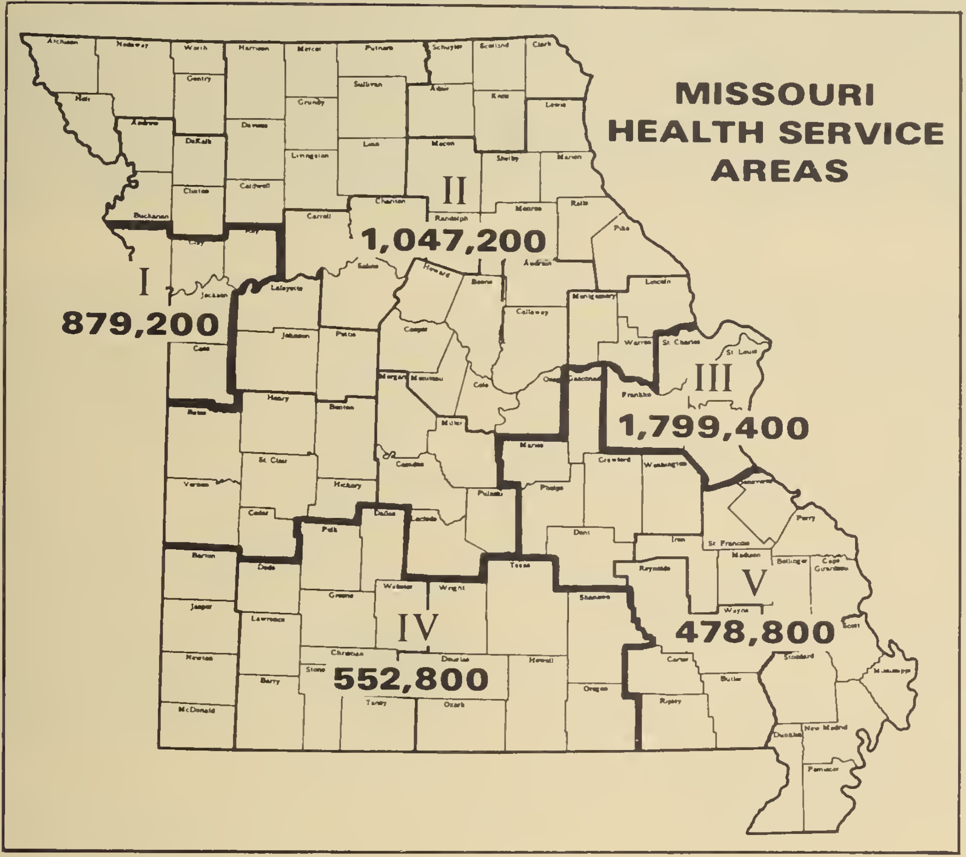
MSMA

NEWS ROUND - UP

SEPTEMBER, 1975



New Health Planning Law is explained

A statewide meeting for the purpose of explaining ıe National Health Planning and Resource Development Act (PL 93-641) was held Aug. 19 in Jefferson ity.

The new law will eliminate state and area Com-ehensive Health Planning Agencies, Regional Medi-l Programs, the Hill-Burton Program and the Experi-ental Health Delivery Systems Program.

Co-sponsored by the Mid-Missouri Regional Medical rogram and the Missouri Department of Social Ser-ces, the meeting dealt primarily with the evolution of ıe law, a slide show illustrating the intent of the law ıd the function of Health Service Agencies (HSA's), ıd forms of assistance available to HSA's.

Most of the meeting attendees represented various ea CHP's and RMP's across the state. It appeared ıat the meeting was held in order to add impetus to cal groups to begin forming HSA's in their areas.

The state is divided into five Health Service Areas ee map) which were selected by Gov. Christopher Bond and approved by the Department of Health, Education and Welfare. The law provides for the formation of a Health Systems Agency in each area. The agency may either be public or private non-profit organization with a consumer-majority board or advisory board.

The law also calls for the creation of a State Health Planning and Development Agency (Gov. Bond designated this agency) and a State Health Coordinating Council.

Some of the powers of the three levels include:

Health Systems Agency

- Assembles and analyzes data on health status and health programs in its area
- Prepares and publishes a Health Systems Plan (HSP) and an Annual Implementation Plan (AIP) for its area
- Implements plans through technical assistance and

Continued on Next Page

Immunization project draws big response by MSMA members

An estimated 1,400 MSMA members have expressed their intention to participate in a project to increase the immunization levels of pre-school children in Missouri.

The project, co-sponsored by the MSMA, MSMA Auxiliary and Missouri Division of Health, is planned to coincide with National Immunization Action Month. Participating MSMA members have agreed to include a free "Immunization Timetable" and "Immunization Record" in their October billing to patients. So far, nearly 180,000 copies of material have been requested.

The lightweight material is being published by the Division of Health and will be mailed to participating members by the first week in September. The material is designed to fit into regular billing envelopes and will not require extra postage.

A few Return Cards have been sent back to MSMA Headquarters requesting a certain number of copies, but the physician neglected to put his name on the card. Therefore, if you ordered copies and do not receive them by mid-September, contact Headquarters and material will be provided.

For those members who wish to participate but did not send in the Return Card, complete the box below and mail to MSMA Headquarters, P.O. Box 1028, Jefferson City, Mo. 65101.

I would like to participate in the MSMA, Woman's Auxiliary and Division of Health project designed to increase the level of immunization in Missouri.

Please send ________ free copies of the "Immunization Timetable" and "Immunization Record" which I can enclose in my October billing. (**No extra postage required.**)

Name ________________________

Address ________________________

City ________________ Zip ________

County Society ________________________

AMA files second suit to halt HEW regulations

The AMA has filed its second lawsuit against Department of Health, Education and Welfare . . . t one seeks to invalidate HEW's Maximum Allowa Cost (MAC) regulations.

Under the MAC regulations, reimbursement Medicare and Medicaid prescription drugs would limited to the least expensive generic form of each di specified in the program, if it is available.

However, MAC rules do permit a physician prescribe drugs by proprietary or brand names if product is certified "medically necessary" in the phy cian's own handwriting.

In its suit, the AMA said the MAC regulations viol the Social Security Act by interfering with the pract of medicine and the patient's right to receive his phy cian's best medical judgment.

As result of the AMA's first law suit against HE the government has postponed indefinitely the eff tive date of its utilization review regulations.

Malpractice rate hike asked

The Insurance Services Office, an independe agency which recommends rates used by sever carriers in Missouri, has requested a 157% i crease in medical professional liability rates the state effective immediately.

The Missouri Division of Insurance is current reviewing the request.

Component societies to meet

Component county medical societies are urged name two representatives to attend a meeting of Cou ty Society Officers, Oct. 17-18, 1975, at the Lodge of t Four Seasons at the Lake of the Ozarks.

A Return Card has been mailed to the President a Secretary of each county society. If these officers ca not attend, the society is urged to appoint two oth representatives.

Area II HSA meeting set

An organizational meeting for a Health Servic Agency in Area II will be held at 1 p.m., Thursday, Se 11, at the Marshall Inn in Marshall.

The open meeting will be sponsored by the Sta Department of Social Services and the Mid-Missou Regional Medical Program.

New National Health Planning Law explained

Continued from Previous Page

through developmental grants to community agencies

- Reviews and approves each use of federal health funds in its area
- Recommends action on each health service offered in area to state agency
- Reviews and comments to state agency on all capital expenditures and new service projects in area institutions
- Recommends health facilities projects to state agency for funding

State Health Planning and Development Agency

- Conducts state health planning activities
- Serves as agency for capital expenditure review
- Administers certificate of need program
- Reviews new and existing health services in th state
- Coordinates all state health data activities
- Administers federally-assisted facilities constru tion activities

State Health Coordinating Council

- Reviews and coordinates Health Systems Agenc plans
- Prepares a state health plan
- Reviews and comments on Health Systems Agenc budgets and applications
- Reviews and approves or disapproves all state plar and applications for funds under federal healt legislation

Malpractice Committee Hearing

embers of the Missouri Senate Select Committee on Malpractice listen to testimony at a hear-
ig held Aug. 21 in St. Louis. Committee members are (from left) Sen. Mary Gant, Kansas City;
n. Richard Webster, Carthage; Ms. Pat Michelson, secretary; Sen. Albert Spradling, Cape
rardeau; Sen. William Cason, Clinton; Sen. Paul Bradshaw, Springfield; and Sen. Harry Wig-
ns, Kansas City.

'Competency' bill drafted by Senate panel

Another proposed bill addressing the professional liability insurance problem was discussed at the third hearing of the Missouri Senate Select Committee on Malpractice in St. Louis on Aug. 21.

Also, the Committee announced its first out-state hearing to be held Friday, Sept. 19, at the Ramada Inn in Cape Girardeau. The meeting will begin at 10 a.m. and it is hoped that a large number of out-state physicians will be on hand to testify and express support for medicine's point of view.

Much of the Aug. 21 hearing dealt with information presented by the insurance carriers who offer, or did offer, malpractice coverage in Missouri. No solid facts were evident and further studies by the Missouri Division of Insurance are expected to help clear up the question of whether insurance firms in Missouri actually are making money selling medical malpractice policies.

The newest of four proposed bills drafted by the Senate Committee would strengthen the policing powers of the State Board of Registration for the Healing Arts.

The bill would give the Board more power in suspending or revoking a physician's license due to medical incompetency, the use of treatments which are contrary to acceptable medical standards, or the consistent utilization of services which are medically inappropriate. In enforcing these rules, the Board could require a physician to submit to a medical competency re-examination.

Proposed bills drafted earlier by the Committee would (1) Set a limit of $500,000 on malpractice awards and limit attorney fees to no more than 33 1/3%; (2) Retain the present Statute of Limitations on Malpractice and lower the limit as applied to minors; and (3) Establish malpractice screening panels in each Congressional District to review suits before they could be heard in court. However, each of the drafts will require minor changes in language.

Sen. Albert M. Spradling, Cape Girardeau, Chairman of the Committee, and other Committee members have expressed disappointment in the poor attendance of physicians and insurance firms at the hearings. Spradling stated that physicians across the state are complaining about the malpractice situation, yet they will not take the time or show the interest to attend this important round of hearings.

Spradling said that although his Committee will be primarily responsible for passage of any legislation in the malpractice area, very few physicians seem concerned enough to share their ideas with the lawmakers.

MSMA continuing education program set

Editor's Note

The MSMA's voluntary Continuing Medic Education program will begin on Jan. 1, 1976. the next several months, a series of articles e plaining the CME program will be published MISSOURI MEDICINE.

The Missouri State Medical Association House of Delegates at the 1971 Annual Meeting approved a plan proposed by the Ad Hoc Committee on Continuing Medical Education. This document presents a plan which the MSMA is implementing under the auspices of the American Medical Association in order to serve as an accrediting body for institutions and organizations which provide local CME programs in the State of Missouri.

The primary objective of this accreditation program is to identify and document programs of Continuing Medical Education in Missouri that satisfy the "essentials of approved programs in Continuing Medical Education" as defined by AMA. Such accreditation may serve as an incentive to institutions and organizations to provide programs which are based on actual and determined educational needs of physicians. This is insure that the quality of medical care in Missouri c be maintained at a high level.

The concept of "lifetime learning" has become an a cepted fact among practicing physicians. It is necessity in order to maintain a level of competen that will insure quality patient care.

In January, 1976, the MSMA will begin conducting voluntary CME program and will recognize physicia who have completed minimum requirements of cc tinuing medical education (150 hours obtained over three-year period of time). Physicians who have co pleted the 150 hours will receive the MSMA and AM Physicians Recognition Award.

Categories of Continuing Medical Educatio

CATEGORY I: CME Activities with Accredite Sponsorship

Education activities that are a planned program CME and sponsorship by an accredited organization.

An accredited organization is one that has been a credited for its CME activities by the Council on Mec cal Education of AMA. Institutions that spons locally-oriented CME activities can be accredited no by the Missouri State Medical Association as it ha been approved by the Council on Medical Education the AMA.

CATEGORY II: CME Activities with Non-A credited Sponsorship

Credit in this category may be claimed for CME a tivities sponsored by a medical organization or instit tion that is not accredited for CME.

CATEGORY III: Medical Teaching

Credit may be claimed for student-contact teachir of medical students, interns, residents, practicir physicians and allied health professionals.

CATEGORY IV: Papers, Publications, Books, Pr sentations and Exhibits

Ten credit hours may be claimed for a paper, public tion or for each chapter of a book that is authored ar published. A paper must be published in a recogniz medical journal. For credit, a presentation or an exhib must be shown to a professional audience which can i clude audiences made up of allied health professional Credit may be claimed only the first time the scientif materials are presented.

CATEGORY V: Non-Supervised Individual CM Activities

Credit may be claimed in this category for CME a tivities that are not personally supervised. The appl cant's statement of the kind and amount of non-supe vised individual CME activities he has completed wi be accepted.

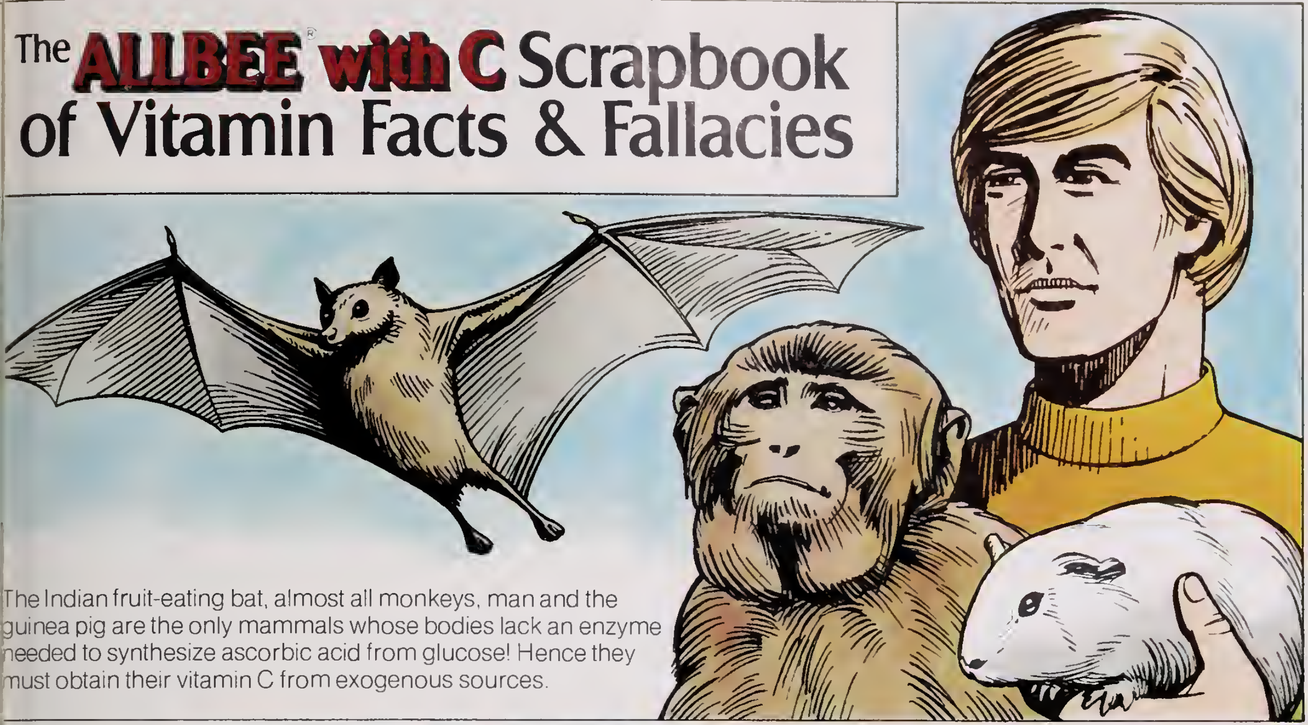
CEMPROC approved

On May 14, 1975 the Secretary of the Department of Health, Education, and Welfare published in the *Federal Register* a notice in which he announced his intention to enter into an agreement with the Central Eastern Missouri Professional Review Organization Committee, designating it as the Professional Standards Review Organization for PSRO Area III located in the State of Missouri.

Such notice was also published in three consecutive issues of *The St. Louis Globe-Democrat* and the *St. Louis Post-Dispatch* on May 14, 15, and 16, 1975. In addition, copies of the notice were mailed to organizations of practicing doctors of medicine and specialty societies, and hospitals and other health care facilities in the area, with a request that each such society or facility inform those doctors in its membership or on its staff who are engaged in active practice in PSRO Area III of the contents of the notice.

The notice requested that any licensed doctor of medicine or osteopathy engaged in active practice in PSRO Area III who objects to the Secretary entering into an agreement with the Central Eastern Missouri Professional Review Organization Committee on the grounds that such organization is not representative of doctors in PSRO Area III, mail such objection in writing to the Director, Office of Professional Standards Review, on or before thirty days after such notice appeared in the *Federal Register*.

After reviewing the final tabulation of objections from doctors of medicine or osteopathy in PSRO Area III, the Secretary has determined that not more than 10 percentum of the doctors engaged in the active practice of medicine or osteopathy in PSRO Area III have expressed timely objection to entering into an agreement with CEMPROC. Therefore, the Secretary has entered into an agreement with the Central Eastern Missouri Professional Review Organization Committee designating it as the Professional Standards Review Organization for PSRO Area III in Missouri.



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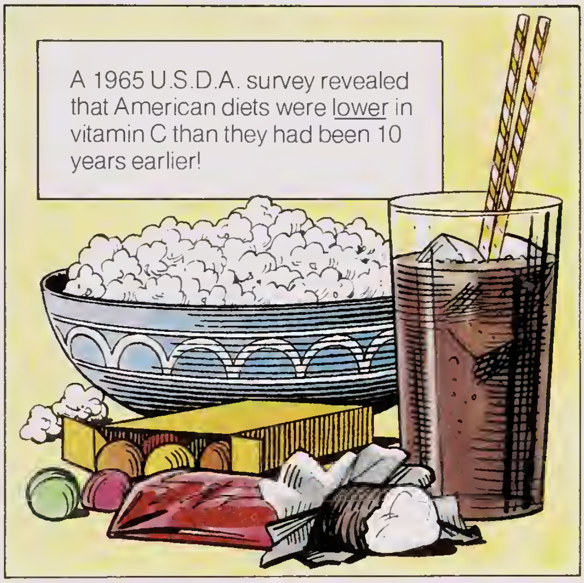
The Indian fruit-eating bat, almost all monkeys, man and the guinea pig are the only mammals whose bodies lack an enzyme needed to synthesize ascorbic acid from glucose! Hence they must obtain their vitamin C from exogenous sources.

De Joinville writing about a 13th century crusade reported that barber surgeons had to "cut away the dead flesh from the gums to enable people to masticate their food." The disease he described was probably scurvy.



A 1965 U.S.D.A. survey revealed that American diets were lower in vitamin C than they had been 10 years earlier!

The outer leaves of cabbage and brussels sprouts contain more vitamin C than the heads. Yet, ironically, these are often trimmed away by the grocer to improve appearance and enhance sales appeal! Many housewives trim them even more before cooking!

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phenobarbital	(¼ gr.) 16.2 mg	(½ gr.) 32.4 mg	(¾ gr.) 48.6 mg.
(warning: may be habit forming)			

Brief summary. Adverse Reactions: Blurring of vision, dry mout difficult urination, and flushing or dryness of the skin may occur c higher dosage levels, rarely on usual dosage. Contraindication Glaucoma; renal or hepatic disease; obstructive uropathy (for e ample, bladder neck obstruction due to prostatic hypertrophy) c hypersensitivity to any of the ingredients.

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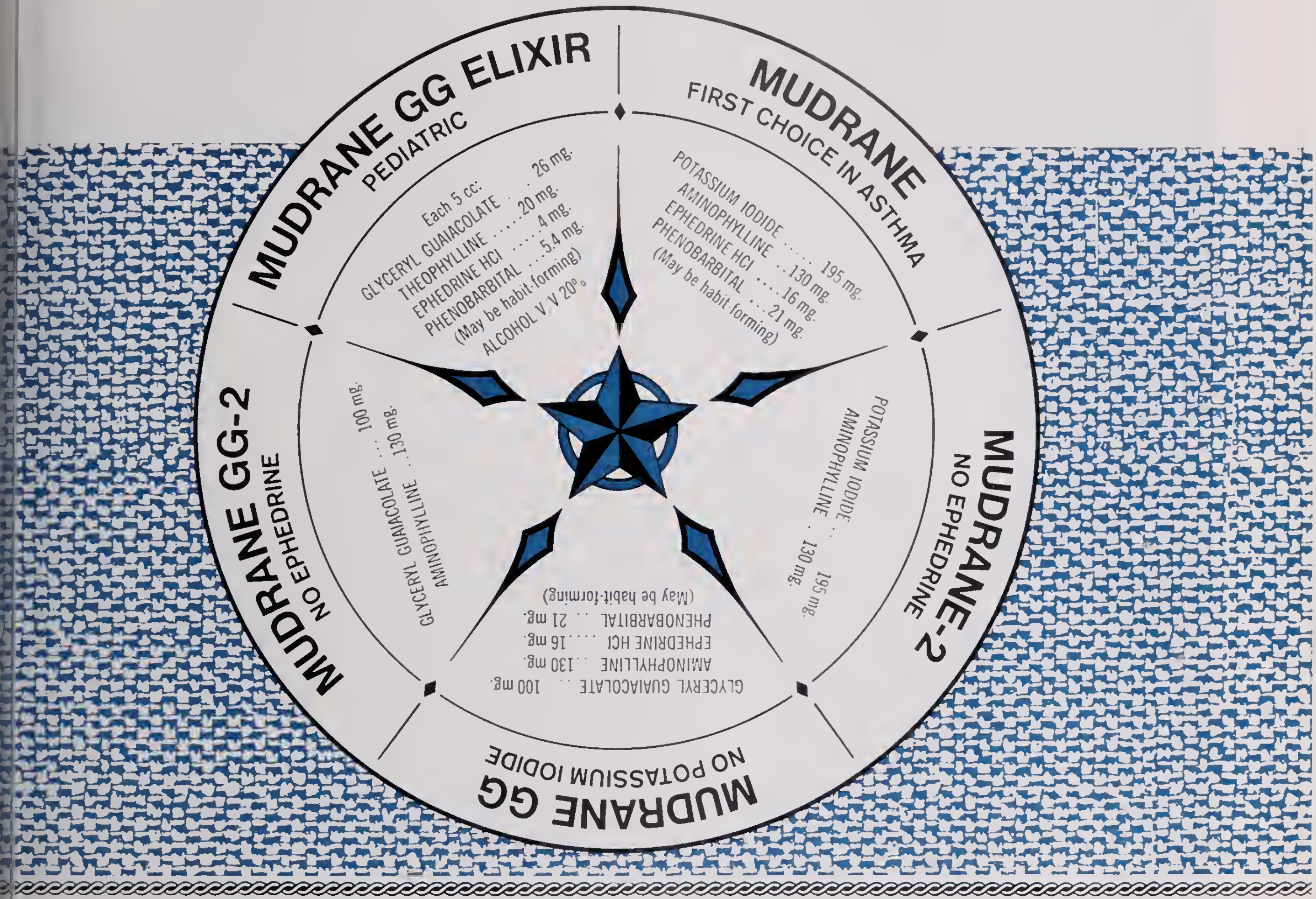
MUDRANE
FIRST CHOICE IN ASTHMA
POTASSIUM IODIDE ..... 195 mg.
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EPHEDRINE HCl ....16 mg.
PHENOBARBITAL ...21 mg.
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MUDRANE-2
NO EPHEDRINE
POTASSIUM IODIDE . . 195 mg.
AMINOPHYLLINE . 130 mg.
MUDRANE GG
NO POTASSIUM IODIDE
GLYCERYL GUAIACOLATE ... 100 mg.
AMINOPHYLLINE ..130 mg.
EPHEDRINE HCl ....16 mg.
PHENOBARBITAL .. 21 mg.
(May be habit-forming)
MUDRANE GG-2
NO EPHEDRINE
GLYCERYL GUAIACOLATE ... 100 mg.
AMINOPHYLLINE ..130 mg.
MUDRANE GG ELIXIR
PEDIATRIC
Each 5 cc:
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INDICATIONS: For the prompt symptomatic relief of bronchial asthma, emphysema and bronchiectasis. The Mudranes dilate the bronchi and liquefy mucus plugs. DOSAGE: Tablet; One tablet with a full glass of water 3 or 4 times daily as required. Divide tablet for child's dose. Elixir; Children, 1 cc for each 10 lbs. of body weight. May be repeated 3 or 4 times a day. Adult, one tablespoonful 4 times daily. All doses should be followed with a glass of water.

CONTRAINDICATIONS: Aminophylline/Theophylline is contraindicated in the presence of severe cardiac arrhythmias and patients with massive myocardial damage. Ephedrine, in presence of severe heart disease, extreme hypertension, and in hyperthyroidism. Phenobarbital, in porphyria and in patients with known phenobarbital sensitivity. Potassium Iodide, in pregnancy (to protect the fetus against possible iodine-induced depression of thyroid activity), in tuberculosis (produces gumma dissolution), and in acne; also in the presence of known iodide sensitivity. PRECAUTIONS: Aminophylline/Theophylline should be avoided in patients with massive myocardial damage and/or severe cardiac arrhythmias. In children, overdose may cause vomiting, cardiac arrhythmias, and severe agitation. Ephedrine should be used with caution in the presence of severe cardiac disease, particularly arrhythmias and angina pectoris; avoid in hyperthyroidism and severe hypertension. Phenobarbital may be habit-forming. Avoid overdosage. Potassium Iodide: Discontinue in the presence of skin rash, swelling of the eyelids and severe frontal headache. Long use may cause goiter. ADVERSE REACTIONS: Aminophylline/Theophylline may cause nausea, cardiac arrhythmias, and aggravate severe myocardial disease. It may cause headaches and tachycardia. Vomiting and dizziness are not uncommon. Ephedrine: In patients hypersensitive to CNS stimulation, ephedrine may cause nervousness, tachycardia, extrasystole and ventricular arrhythmias. May cause urinary retention, especially in the presence of partial prostatic obstruction. Psychoneurosis may be aggravated. Pre-existing anginal pain will be aggravated. Phenobarbital may produce severe skin rash. Avoid overdosage. May be habit-forming. Potassium Iodide may cause nausea. Over very long period of use, iodides cause goiter. Discontinue if patient develops skin rash, eye irritation, eyelid swelling, or severe frontal headache.

HOW SUPPLIED: Mudrane and Mudrane GG available in bottles of 100 and 1000 tablets; Mudrane-2 and Mudrane GG-2 in 100s; Elixir in pints and half-gallons.

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Ortho-Novum SQ
TRADEMARK

white tablet contains 0.08 mg mestranol. Each blue tablet contains 2.0 mg norethindrone and 0.08 mg mestranol.

†Serious as well as minor conditions have been reported following the use of oral contraceptives. These conditions include thromboembolic disease. The physician should remain alert to the earliest manifestations of any symptoms of serious disease and discontinue oral contraceptive therapy when appropriate. The physician should be fully aware of the complete Prescribing Information for this product.

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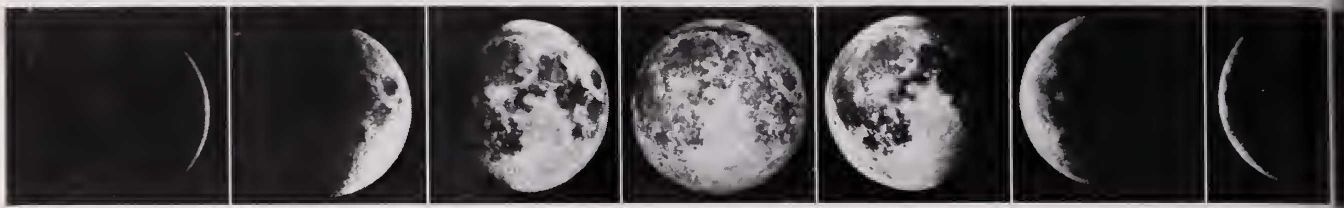
In sequence...



Ortho-Novum SQ Tablets

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Description: ORTHO-NOVUM SO Tablets provide a sequential oral contraceptive regimen consisting of white tablets containing only mestranol 0 08 mg. and blue tablets containing both mestranol 0 08 mg and norethindrone 2 0 mg
Action: Gonadotrophin suppression
Special note: Oral contraceptives have been marketed in the United States since 1960 Reported pregnancy rates vary from product to product The effectiveness of the sequential products appears to be somewhat lower than that of the combination products Both types provide almost completely effective contraception

An increased risk of thromboembolic disease associated with the use of hormonal contraceptives has now been shown in studies conducted in both Great Britain and the United States Other risks, such as those of elevated blood pressure and reduced tolerance to carbohydrates, have been reported and appropriate tests should be conducted to monitor these during oral contraceptive therapy Liver disease has also been reported, and the physician should be alert to its earliest manifestations

Long-term administration of both natural and synthetic estrogens in subprimate animal species in multiples of the human dose increases the frequency for some animal carcinomas These data cannot be transposed directly to man The possible carcinogenicity due to the estrogens can neither be affirmed nor refuted at this time Close clinical surveillance of all women taking oral contraceptives must be continued
Indication: Contraception
Contraindications: 1 Thrombophlebitis, thromboembolic disorders, cerebral vascular disease, or a past history of these conditions 2 Markedly impaired liver function 3 Known or suspected carcinoma of the breast 4 Known or suspected estrogen-dependent neoplasia 5. Undiagnosed abnormal genital bleeding 6 Known or suspected pregnancy
Warnings: 1 The physician should be alert to the earliest manifestations of thrombotic and thromboembolic disorders, thrombophlebitis, cerebrovascular disorders including hemorrhage, pulmonary embolism and retinal thrombosis Should any of these occur or be suspected, the drug should be discontinued immediately

Retrospective studies of morbidity and mortality in Great Britain and studies of morbidity in the United States have shown a statistically significant association between thrombophlebitis, pulmonary embolism and cerebral vascular disease, occlusive or hemorrhagic, and the use of oral contraceptives There have been three principal studies in Great Britain[1-3] leading to these conclusions and three in this country [4-7] The estimate of the relative risk of thromboembolism in the study by Vessey and Doll[3] was about sevenfold, while the United States studies found relative risks of 4 4 to 11, meaning that the users are several times as likely to undergo thromboembolic disease without evident cause as non-users

In May, 1974, the Royal College of General Practitioners in England[8] issued an interim report of its continuing large-scale prospective study comparing a user group to a non-user group This study in its interim analysis states, A statistically significant higher rate of reporting of cerebrovascular accidents in Takers is evident, but the numbers are too small to justify an estimation of the degree of risk The study also reported a higher incidence of superficial and deep vein thrombosis in users as compared to non-users The risk of superficial and deep vein thrombosis was reported to be lower in women using 50 mcg estrogen preparations

The Sartwell study[4] indicated that the risk did not persist after discontinuation of administration. Both the Sartwell and the Royal College studies indicated that the degree of risk was not associated with duration of treatment

In a collaborative American study[5,6] of cerebrovascular disorders in women with and without predisposing causes it was estimated that the relative risk of thrombotic stroke was 4 1 to 9 5 times greater in users than in non-users A comparable estimate for hemorrhagic stroke was 2 0

None of the American studies was designed to evaluate a difference between products However, the Sartwell study[4] suggested that there might be an increased risk of thromboembolic disease in users of sequential products

Other retrospective studies[9,10] have reported an increased risk of post-surgery thromboembolic complications in oral contraceptive users It has been recommended that therapy be discontinued at least one month prior to elective surgery
2 Discontinue oral contraceptive medication if there is gradual or sudden partial or complete loss of vision, proptosis or diplopia, onset or aggravation of migraine or development of headache of a new pattern which is recurrent, persistent or severe, papilledema, or any evidence of retinal vascular lesions
3 Fetal abnormalities have been reported to occur in the offspring of women who have taken progestogens and or estrogens during pregnancy [11,12] The safety of ORTHO-NOVUM SO in pregnancy has not been demonstrated Pregnancy should be ruled out before initiating or continuing the contraceptive regimen Pregnancy should always be considered if withdrawal bleeding does not occur
4 A small fraction of the hormonal agents in oral contraceptives has been identified in the milk of mothers receiving these drugs. The long-range effect to the nursing infant cannot be determined at this time
5 Hepatic lesions (adenomas, hepatomas, hamartomas, regenerating nodules, etc.), occasionally fatal, have been reported in women on oral contraceptives. Such lesions may present as an abdominal mass or with the signs and symptoms of an acute abdomen These lesions should be considered if the patient has abdominal pain or evidence of intra-abdominal bleeding. This has been reported in short-term as well as long-term users of oral contraceptives

Precautions: 1 A thorough history and physical examination should be performed befor
ing oral contraceptives and periodically during their administration and should include sp
ence to breasts and pelvic organs, including Papanicolaou smear since estrogens have be
to produce tumors, some of them malignant, in five species of subprimate animals 2 Endo
possibly liver function tests may be affected by treatment with ORTHO-NOVUM SQ Th
such tests are abnormal in a patient taking ORTHO-NOVUM SO, it is recommended tha
repeated after the drug has been withdrawn for two months. 3. Under the influence of
progestogen preparations, pre-existing uterine fibromyomata may increase in size 4 Becar
agents may cause some degree of fluid retention, conditions which might be influenced by t
such as epilepsy, migraine, asthma, cardiac or renal dysfunction, require careful observa
breakthrough bleeding, and in all cases of irregular bleeding per vaginam, nonfunctiona
should be borne in mind In undiagnosed bleeding per vaginam, adequate diagnostic mea
indicated 6 Patients with a history of psychic depression should be carefully observed and
discontinued if the depression recurs to a serious degree 7 Any possible influence of p
ORTHO-NOVUM SO therapy on pituitary, ovarian, adrenal, hepatic or uterine function awa
study 8 A decrease in glucose tolerance has been observed in a significant percentage of
on oral contraceptives The mechanism of this decrease is obscure. For this reason, diabetic
should be carefully observed while receiving ORTHO-NOVUM SQ therapy 9 The age of th
constitutes no absolute limiting factor, although treatment with ORTHO-NOVUM SQ may
onset of the climacteric 10 The pathologist should be advised of ORTHO-NOVUM SQ thera
relevant specimens are submitted. 11. Susceptible women may experience an increase
pressure following administration of contraceptive steroids 12. Cholestatic jaundice h
reported in users of oral contraceptives If this occurs, ORTHO-NOVUM SO should be disc
This condition is more likely to occur in patients who have experienced cholestatic jaundic
nancy Patients with a history of cholestatic jaundice of pregnancy should be carefully obse
ing ORTHO-NOVUM SQ therapy

Adverse reactions observed in patients receiving oral contraceptives: A statistically s
association has been demonstrated between use of oral contraceptives and the following
adverse reactions thrombophlebitis, pulmonary embolism, cerebral thrombosis and hem
gallbladder disease

Although available evidence is suggestive of an association, such a relationship has bee
confirmed nor refuted for the following serious adverse reactions neuro-ocular lesions, e g
thrombosis and optic neuritis, hepatic lesions with or without intra-abdominal bleeding

The following adverse reactions are known to occur in patients receiving oral contra
nausea, vomiting, gastrointestinal symptoms (such as abdominal cramps and b
breakthrough bleeding, spotting, change in menstrual flow, amenorrhea during and after t
edema, chloasma or melasma, which may persist, cholestatic jaundice, migraine, rash
mental depression, change in weight (increase or decrease), breast changes (tenderness
ment and secretion), changes in cervical erosion and cervical secretions, suppression of
when given immediately post-partum, rise in blood pressure in susceptible individuals

Although the following adverse reactions have been reported in users of oral contracep
association has been neither confirmed nor refuted anovulation post-treatment, which tends
more frequently in women with a history of menstrual disorders, premenstrual-like sy
changes in libido, changes in appetite, cystitis-like syndrome; headache; intolerance to co
ses, nervousness, dizziness, fatigue, backache, hirsutism; loss of scalp hair, erythema mu
erythema nodosum, hemorrhagic eruptions; itching, vaginitis.

The following laboratory results may be altered by the use of oral contraceptives hepatic f
increased sulfobromophthalein retention and other tests; coagulation tests—increase in prot
Factors VII, VIII, IX and X, decrease in anti-thrombin III, increase in platelet aggregability
function—increase in PBI, and butanol-extractable protein-bound iodine and decrease in T
values; metyrapone test, pregnanediol determination

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ELEANOR SHAHEEN, M.D., S. A. HUSAIN, M.D. *a*
JANICE HAYS, M.S.W., *Columb*

Child Abuse—A Medical Emergency

Child abuse, a clinical condition in infants and children who have received serious physical injury, is a frequent cause of permanent injury or death. This disease should be considered in any child with fractures, subdural hematoma, failure to thrive of nonorganic etiology, bruises, burns, sudden death or when the degree and type of injury are not compatible with the history given. The physician has three main responsibilities in child abuse cases—detection, reporting and participation in the family treatment process.

Historical Background

Children have been victims of adult abuse from antiquity. Solomon[1] cites examples from biblical, classical Greek, Scandinavian and other cultures. Ancient philosophers often beat their pupils unmercifully.[2] Flogging the children without provocation was common practice in Colonial America, in order to "break them of their willfulness" and make them tractible, ostensibly for the good of their souls.[3] "Spare the rod and spoil the child" reflected the attitude of society towards its young ones until recently. However, it was not until the last 15 years that the seriousness and widespread occurrence of this clinical entity has made itself felt in medical literature.

John Caffey[4] (1946) was the first to report radiological findings of six infants with chronic subdural hematoma and associated multiple fractures of long bones.

Silverman[5] (1953) was probably the first to suggest that parents might inflict trauma on their own children and then proceed to deny this in giving the case history. Wooley[6] (1955), in a study of all the cases of infant injury between 1946-1954 at the Children's Hospital of Michigan, identified 12 cases which he felt showed characteristics of inflicted multiple skeletal lesions in infants. He pointed out that parental abuse and not the metabolic and structural abnormality was the etiologic factor.

Henry Kempe[7] and his group from the University of Colorado, however, were the first to put the pieces together. In 1962, they surveyed reports from 71 hospitals and 77 district attorneys and collected records of 749 cases of recorded batterin The clinical picture of multiple skeletal fractur subdural hematoma, multiple soft tissue injuri and neglect was termed "Battered Child Sy drome" by Kempe at an American Academy Pediatric Symposium in 1961. Since then, nume ous reports have appeared identifying addition cases, further refining the characteristics, identif ing the abused child and stressing the need for r porting cases to the proper agencies.

Definition

Gil[8] has defined child abuse as a "nonaccident physical attack or physical injury inflicted up children by persons caring for them." Howeve most authors favor a broader definition to incluc other problems which arise as the result of lack reasonable care and protection of children. Sa mon[9] pointed out that emotional battering is common concomitant of physical injury and su gests that the physician look for apathy, terro misery, "frozen watchfulness" and "persistent cr ing" in a small child as diagnostic pointers. At th extreme end of the spectrum are children who ar victims of violent and severe abuse and, henc easily identified. At the other end are those wit more subtle, less dramatic symptoms arising fro passive rejection from the parents or their su rogate.

Incidence

Of the 200,000 to 250,000 children who a abused annually in the U.S.A., 30,000 to 37,00 may have been badly injured.[2] Twenty-five perce of all fractures seen in the first two years of li are due to the Battered Child Syndrome.[10]

The mortality rate of abused children is hig Kempe estimated[11] that at least 700 children ar killed every year in the United States by their pa ents or parent substitutes. Adelson[12] felt that th problem may be even more widespread and su gests that autopsies be done on all children wh died without adequate reasons.

Twenty-five percent to 50% of children are ba tered again when they are returned to their pa ents.[13] According to one study, one of every tw ildren die after being returned to their parents ithout intervention.[14]

In Missouri, statistics are kept by the Division of mily Services in Jefferson City. During 1974, ere was a total of 1,462 cases reported. A break- own of these cases shows that 49% of the cases ere from rural areas. The victim was male in .3% of the cases and white in 75.8%. The mother as reported as the perpetrator in 35.7% of the cases d the father in 37.3%. Both were reported in 3%. Fifteen percent of all cases of confirmed use or neglect were referred to the Juvenile ourt for foster care. More than half of the chil- en were preschoolers. There were eleven fatali- s.

ho Are the Abused?

Schmitt and Kempe report the following:

1. About one third of abused children are under months of age, one third from six months to ree years and one third are over three years of e.[15]
2. Premature infants are a 3:1 greater risk than ll-term babies.[15]
3. "The incidence of physical abuse is 6/1,000 e births. The prevalence is approximately 300 ses per million population."[15]
4. "Approximately 10% of injuries seen in a hos- tal emergency room in children under the age of e are inflicted."[15]
5. Failure to thrive or growth failure of non- ganic etiology is reported with one fourth the equency of child abuse.[15]
6. "If the child is returned to his parents without y intervention, 5% are killed and 35% are seriously injured."[15]

ho Are the Abusers?

"Over 90% of abusing parents are neither psy- otic nor sociopaths. They have injured their chil- ren in anger after being provoked by some mis- havior, imagined or real. They often have ex- rienced physical abuse themselves when they ere children.

"For physical abuse to occur, it requires not only e right parent but, also, the right child and the ght day. The right child has characteristics that ake him demanding. The right day usually is a ay of crisis. The most common crises include los- g a job, being evicted, having the car break own, birth of a sibling or an acute illness which ads to intractable crying."[15]

Of the more than 200,000 children who are abused annually in the United States, 30,000 to 70,000 may have been badly injured. It has been estimated that at least 700 children are killed every year by their parents or parent substitutes. The physician has three primary responsibilities in cases of child abuse—detection, reporting and participation in the family treatment process. Whenever a small child presents with trauma, the history of child abuse should be considered.

The authors are from the University of Missouri Medical Center where Dr. Shaheen is Professor and Associate Chairman, Department of Child Health; Dr. Husain is Assistant Professor, Department of Psychiatry; and Ms. Hays is Instructor, Department of Child Health.

Abusing parents come from all socio-economic geographical, occupational, racial and ethnic groups. Poor families may have a higher incidence of (reported) child abuse because of increased crises and fewer available resources.[15]

The abusing parent is usually the parent who spends the most time with the child. The spouse may be knowledgeable of the abuse but will passively allow it to continue by ignoring or denying its existence.[15]

Making the Diagnosis of Child Abuse and Neglect

Whenever a small child presents with trauma, the history of child abuse should be considered. All children in whom the problem is suspected should be admitted to the hospital. A *positive* diagnosis of child abuse can rarely be made in the emergency room or clinic where the abused or neglected child is likely to be seen first. Physicians are usually too busy, parents are upset and diagnostic studies are too time consuming. Specialized personnel often are unavailable on short notice.

The parents should *not* be confronted with the possibility of child abuse at the emergency room level. The recommendation for admission can be truthfully explained as the need for further treatment and diagnosis. Very few parents will refuse the physician's request for hospitalization unless they have been frightened. In the rare event that admission is refused and the physician feels the child is in immediate danger, the Division of Family

Services can be contacted and requested to take the child into immediate custody. (Note: A revision to the Missouri child abuse law has recently been passed which allows physicians to detain children in the hospital for a maximum of 20 hours.)

The following are helpful criteria:[16]

A. History

Child abuse should be considered when the parents:

1) present a history which conflicts with the nature of the injury;

2) are inconsistent or contradictory;

3) appear to be mentally ill or under the influence of drugs or alcohol;

4) over- or under-react to the seriousness of the situation;

5) are out of control or fear loss of control;

6) appear to behave inappropriately with the child or complain about unrelated problems;

7) have unrealistic expectations of the child;

8) give history of repeated accidents;

9) refuse to cooperate with the physician;

10) hospital "shop";

11) perceive the child as "different"; or

12) expect the child to meet the parents' needs.

B. Physical Examination

Children who have been abused or neglected often:

1) show signs of malnutrition and dehydration without obvious cause;

2) have an unexplained or "hidden" injury;

3) shows signs of repeated injuries;

4) have been given inappropriate food, drink or drugs;

5) are unusually fearful; or

6) show evidence of overall poor care.

All bruises, cuts and burns should be photographed.

C. Radiological Examination

An x-ray survey consisting of long bones, skull, ribs, and pelvic films will often clinch the diagnosis of physical abuse.[17, 18] A trauma survey should be obtained on all patients with suspected physical abuse or nutritional neglect. Often multiple bone injuries at different stages of healing are seen, implying repeated injury.[15]

D. Laboratory Data

"The diagnosis of inflicted bruises requires a bleeding screen which includes a bleeding time, platelet count, partial thromboplastin time and prothrombin time. This can quickly determine whether or not the patient actually "bruises easily."

"A child with failure to thrive and an otherw normal physical examination requires very fe baseline laboratory tests. A complete blood cou erythrocyte sedimentation rate, urine analys urine culture, serum electrolytes, calcium and BU are adequate."[15]

E. Other criteria are as follows:

The nurse and social worker can provide val able information regarding family history, comp sition and current living situation, existing cris and contacts with community agencies. From t first day of hospitalization, these disciplines can helpful in the management of child abuse a neglect. Within a short period of time, the phy cian and the other staff will be able to determi whether the case should be reported according state reporting statutes.[16]

When Should a Report be Made?

A report should be made when there is a *hig index of suspicion.* Child abuse should be suspe ed when the parent's explanations for the chil injuries appear to be guarded, confused, confli ing or implausible or if a child repeatedly requir treatment for injuries. It is not the responsibili of the medical staff to prove that the child w abused, but only to report that the explanatio for the child's condition seemed inadequate.[19]

The Missouri Law

In 1969, the Missouri legislature passed a mand tory reporting statute which reflected the growi awareness of the severity of child abuse and n glect. In 1975, the legislature revised this statut (RS Mo. 559.330 to 559.340) which is known as th child abuse law. The law makes failure to repo child abuse or neglect by anyone responsible for th care of children a misdemeanor.

All physicians, nurses, hospital administrato and others responsible for the care of children a required by law to report to the local Division Family Service when there is a reasonable beli that a child has been abused or neglected. Th doctor-patient privilege does not exempt the ph sician from reporting.

The intent of this law is to insure the safety children who are too young, frightened or sick ask for help. Most families can be rehabilitat and punishment of the parents should be avoid as long as there is reasonable hope for preservi the family unit. In extreme cases, the law provid for involuntary termination of parental rights.

Anyone reporting child abuse and neglect god faith is exempt from any civil or criminal l suits.[19]

CMMUNITY RESOURCES

Helping abusive and neglectful families can be a difficult and time consuming task for any one pfession. (Even in the smallest county, there are csiderable resources aimed at prevention and tatment.)

The primary resources, which have ultimate lal responsibility for follow-up and treatment, a the county Division of Family Service, which pvides protective casework, and the Circuit Court jenile officer. Perhaps less often included but qite effective is the public health nurse. Her role i teaching sound parenting skills and providing iensive follow-up can be invaluable. Many counts also have extension nutrition aides and other pfessions with potential for providing a support stem to a troubled family. Mental health resrces, either local or through outreach services, c be incorporated into the total treatment plan. Hwever, agency efforts need to be coordinated ad constant communication with all care provide is essential.

At the University of Missouri-Columbia Medic Center, a consultative team has been formed t assist physicians in making the diagnosis and tatment plan in child abuse and neglect cases. Te team consists of a pediatrician, a social worke coordinator and a nurse practitioner and has acte consultants from psychiatry, pediatric radiology and legal counsel. Although the grant which made formation of the Child Health Abuse and Neglect Team (CHANT) possible specifics primary concentration on local cases, consultation is available at this time without charge to any community usually served by the Medical Center.

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CYRIL COSTELLO, M.D., ***St. Louis***

Medicine in the Time of John T. Hodgen

Special Article

At this 25th annual meeting of the Hodgen Club, our attentions are turned to the St. Louis homecoming at the St. Louis City Hospital, as we remember it in our house-staff days, and to the memory of John T. Hodgen, whom we honor. We pause briefly to think of the year 1882, when Hodgen, one of America's great surgeons and educational leaders, died of acute abdominal disease and we recall the words of his physician, Dr. G. Baumgerten, as he reported on his patient to a special meeting of the St. Louis Medical Society the following evening: "—on Thursday evening, the patient in undescribable agony from bilious colic similar to those he had periodically for some years. There was a tenderness below the ribs on the right side. Chloroform did not relieve him and it was necessary to give frequent injections of Morphine. He had not improved during the night and after a consultation with Drs. Smith, Gregory and Johnson, leeches were applied to the abdomen which showed evidence of generalized peritonitis. The pulse was sinking in volume and increasing in frequency and the extremities were cold. Bleeding from leeches was stopped and stimulants were applied. In the afternoon, the pulse was up between 120 and 140 and became weak and thready. Several doses of atropia staved off the results for a short time but he sank and towards seven, he passed away." Dr. Gregory then gave the autopsy findings of a perforated ulcer of the gallbladder and evidence of generalized peritonitis.

What comprised the practice of medicine at that time, less than a century ago? By present standards, such a death would be considered a medical scandal. Let us, therefore, consider medicine of that time from two vantage points: one, medical practice generally and, two, diagnosis and treatment of gallbladder diseases.

Hodgen was born in 1826 in Hodgenville, Ky., where his lifelong friend, Abraham Lincoln, also first greeted the dawn of day. He attended Missouri Medical College in St. Louis, graduating in 1848. Mullanphy Hospital, the city's first, was then 20 years old while the City Hospital, the second in St. Louis, founded in 1846, was in its second year of operation. Hodgen and his classmate, Ellsworth Smith, were appointed the institution's first inter After a year of training, Hodgen became affiliat with his Alma Mater. He moved, however, in 18 to the faculty of the St. Louis Medical Colle filling respectively the chairs of Anatomy a Physiology, and upon the resignation of Charles Pope in 1865, he was made Dean of the Colle where he continued to serve until his death 1882. Some of Hodgen's publications portray t nature of his surgical practice and include: "Ope tion for Dislocation of the Scapular End of t Clavicle," "Modification of Operation for Lacerat Perineum," "Dislocation of Both Hips," "T Deaths from Chloroform," "Use of Atropia in C lapse of Cholera," "Three Cases of Extrauteri Foetation," "Skin Grafting," "Nerve Section f Neuralgia and Induration of Penis," "Report Antiseptic Surgery," "Shock and Effects of Co pressed Air as Observed in the Building of the Louis and Illinois Bridge."

Prior to the 19th Century, medical practice w indiscriminately mixed with quackery, nostrum soothsaying, tribal custom, etc. In Hodgen's day, became apparent that time for differentiation h arrived. By 1900, there were 160 medical schools Canada and the United States, most of which we of poor quality; and one of the worst spots f diploma mills and fraudulent medical schools w Missouri with 42 schools, one half of which were St. Louis. Hodgen is, perhaps, best remembered American Medicine for his success in organizi and developing a standard of practice at the Louis Medical College which was not even a tempted in other schools for decades, and then on under pressure of developing laws.

The St. Louis Medical Society was founded 1838 and the American Medical Association 1848, both in attempts to organize and standardi medical practice. Hodgen, as a leader in these pr fessional and educational activities, served as pres dent of both of these organizations. Evidentl standard setting was at least as difficult then as continues to be today. Comments by other medic leaders of his time give the impression of the po status of medical practice generally. Dr. Oliv Wendell Holmes, also a professor of Anatomy an ysiology and also the Dean of his (Harvard) dical School, observed in 1860, "I firmly believe t if the whole materia medica as now used uld be sunk to the bottom of the sea, it would all the better for mankind and all the worse for fishes." Dr. Marion Sims expressed a profession- caveat, "—men learn to be honest and do the ht thing or do nothing."

In 1849, the year following Hodgen's internship St. Louis City Hospital, 4,557 persons died in Louis from Asiatic cholera and 4,046 died from her causes. Still others fled in terror from the ty, whose population fell from 70,000 in January 50,000 in July. This was 34 years before Koch lated the comma bacillus, and the profession s then divided on the subject of contagiousness cholera. Not until 1878 did Koch demonstrate t specific diseases resulted from infections by ecific bacteria.

Hodgen's blood pressure was not reported since sphygmomanometer was not devised until five ars after his death, and it was ten to 15 years er his death that antitoxin to diphtheria and anus and the inoculation for typhoid took the ror out of three of the most feared illnesses. Most the accomplished physician's time was spent in actising compassion and analgesia and in repair- injuries or performing amputations for those ich would not heal by nature.

Near the end of Hodgen's abbreviated career, first of the medical miracles were appearing. ster's antiseptic surgical technique had become septic technique." Warren had performed the st operation under ether anesthesia in Boston 846) and with anesthesia and asepsis available, rgery began arising upon its newfound wings. the 1880-to-1890 decade, first successful opera- ns were performed on the stomach, colon, uterus, ctum, appendix, breast, gallbladder and many hers.

The history of gallbladder surgery bears almost nic dates for the 1882 death of Hodgen, since was in that same year that the first successful olecystectomy was performed by Von Winni- rter, and, in that same year, Langenbuch suc- ssfully operated upon four patients. Surgical at- cks upon the diseased gallbladder were first per- rmed by neighbors of Hodgen. Dr. J. S. Bobbs Indianapolis performed the first cholecystostomy 1878 but his patient died, as did the patient upon om the first planned cholecystostomy had been rformed by Marion Sims in the same year.

This interesting historical article was prepared by Dr. Costello as club historian for the 25th Annual Meeting of the Hodgen Surgical Club in St. Louis in May, 1975. The Hodgen Club was organized on Jan. 22, 1951 and is composed principally of American Board certified surgeons who have had some City Hospital (St. Louis) as part of their background. Dr. Costello served as president of the club in 1961.

Before the diagnosis of gallbladder disease could be perfected, other men in other years would be awaited. Roentgen contributed with his discovery of x-rays in 1893. Almost a decade after Hodgen's death, in 1891 the St. Louis Medical College, perfected by Hodgen, became a part of Washington University Medical School and it was here that Evarts Graham, professor of surgery, and his resident surgeon, Warren Cole, in 1923 and 1924 developed the Roentgen diagnosis of gallbladder disease. The "Graham-Cole" test with minor changes continues today as the primary method of diagnosis of diseases of the gallbladder.

Hodgen was a surgical teacher and leader of our profession in the transitional period of medicine when the implements were limited to integrity, ingenuity and scientific research and when the prescriptions consisted principally of dressings, repairs, amputations and, frequently, almost entirely of comfort and compassion for ill and dying patients. These formed the solid foundations which facilitated and assured the "miracle drugs" and "miracle operations" of the 20th Century. The medical miracles of today have been unlike those of medical antiquity because today the miracles really work and have become so successful that they are not only expected but are demanded. Much of the surgeon's expression of compassion and personalized involvement with patients and relatives which formed a large part of the practice in the transitional period became diluted by the never-ending demands for more immediate and miraculous medicine and surgery. Patients casually accepted "miracle medicine" while complaining about the loss of the family physician and friend. This essential ingredient perfected in Hodgen's era is reappearing as though by commands of patient population as surely as they demanded the essential ingredient of science.

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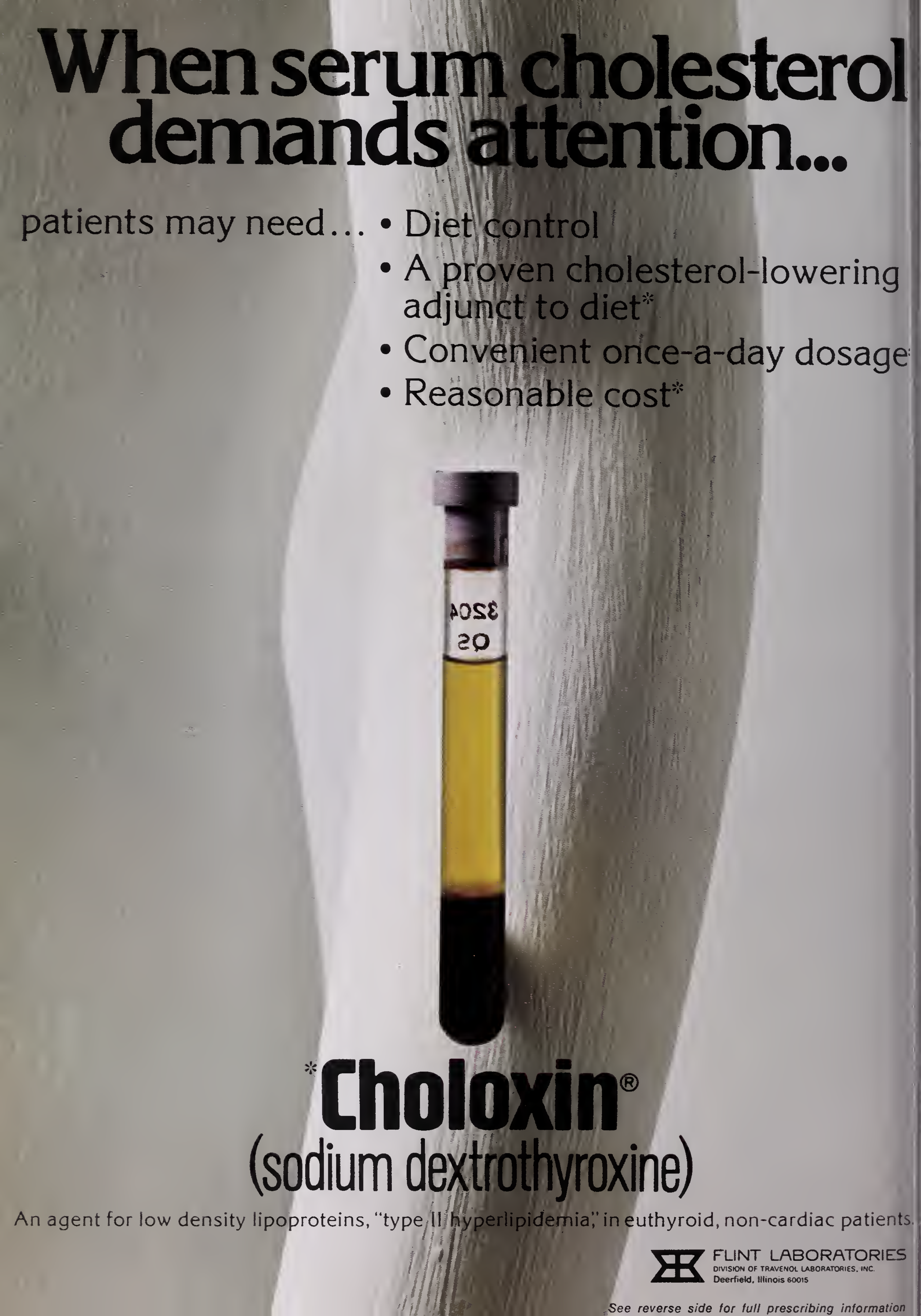

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Before prescribing, note the following: Results from a randomized clinical study have indicated a possible adverse effect when CHOLOXIN is administered to a patient receiving a digitalis preparation. There may be an additive effect. This additive effect may possibly stimulate the myocardium excessively in patients with significant myocardial impairment. CHOLOXIN dosage should not exceed 4 mg per day when the patient is receiving a digitalis preparation concomitantly. Careful monitoring of the total effect of both drugs is important.

It has not been established whether the drug-induced lowering of serum cholesterol or lipid levels has a detrimental, beneficial, or no effect on the morbidity or mortality due to atherosclerosis or coronary heart disease. Several years will be required before current investigations will yield an answer to this question.

Contraindications
The administration of CHOLOXIN (sodium dextrothyroxine) to euthyroid patients with one or more of the following conditions is contraindicated:

1. Known organic heart disease, including angina pectoris; history of myocardial infarction; cardiac arrhythmia or tachycardia, either active or in patients with demonstrated propensity for arrhythmias; rheumatic heart disease; history of congestive heart failure; and decompensated or borderline compensated cardiac status.
2. Hypertensive states (other than mild, labile systolic hypertension).
3. Advanced liver or kidney disease.
4. Pregnancy.
5. Nursing mothers.
6. History of iodism.

Warnings
CHOLOXIN (sodium dextrothyroxine) may potentiate the effects of anticoagulants on prothrombin time. Reductions of anticoagulant dosage by as much as 30% have been required in some patients. Consequently, the dosage of anticoagulants should be reduced by one-third upon initiation of CHOLOXIN therapy and the dosage subsequently readjusted on the basis of prothrombin time. The prothrombin time of patients receiving anticoagulant therapy concomitantly with CHOLOXIN therapy should be observed as frequently as necessary, but at least weekly, during the first few weeks of treatment.

In the surgical patient, it is wise to consider withdrawal of the drug two weeks prior to surgery if the use of anticoagulants during surgery is contemplated.

When CHOLOXIN is used as thyroid replacement therapy in hypothyroid patients with concomitant coronary artery disease (especially those with a history of angina pectoris or myocardial infarction) or other cardiac disease, treatment should be initiated with care. Special consideration of the dosage schedule of CHOLOXIN is required. This drug may increase the oxygen requirements of the myocardium, especially at high dosage levels. Treated subjects with coronary artery disease must be seen at frequent intervals. If aggravation of angina or increased myocardial ischemia, cardiac failure, or clinically significant arrhythmia develops during the treatment of hypothyroid patients, the dosage should be reduced or the drug discontinued.

Special consideration must be given to the dosage of other thyroid medications used concomitantly with CHOLOXIN. As with all thyroactive drugs, hypothyroid patients are more sensitive to a given dose of CHOLOXIN than euthyroid patients.

Epinephrine injection in patients with coronary artery disease may precipitate an episode of coronary insufficiency. This condition may be enhanced in patients receiving thyroid analogues. These phenomena should be kept in mind when catecholamine injections are required in sodium dextrothyroxine-treated patients with coronary artery disease.

Since the possibility of precipitating cardiac arrhythmias during surgery may be greater in patients treated with thyroid hormones, it may be wise to discontinue CHOLOXIN in euthyroid patients at least two weeks prior to an elective operation. During emergency surgery in euthyroid patients, and in surgery in hypothyroid patients in whom it may be advisable to withdraw therapy, the patients should be carefully observed.

There are reports that sodium dextrothyroxine in diabetic patients is capable of increasing blood sugar levels with a resultant increase in requirements of insulin or oral hypoglycemic agents. Special attention should be paid to parameters necessary for good control of the diabetic state in dextrothyroxine-treated subjects and to dosage requirements of insulin or other antidiabetic drugs. If sodium dextrothyroxine is later withdrawn from patients who had required an increase of insulin (or oral hypoglycemic agents) dosage during its administration, the dosage of antidiabetic drugs should be reduced and adjusted to maintain good control of the diabetic state.

When either or both impaired liver or kidney function are present, the advantages of CHOLOXIN therapy must be weighed against the possibility of deleterious results.

Usage in Women of Childbearing Age
Women of childbearing age with familial hypercholesterolemia or hyperlipemia should not be deprived of the use of this drug; it can be given to those patients exercising strict birth control procedures. Since pregnancy may occur despite the use of birth control procedures, administration of CHOLOXIN (sodium dextrothyroxine) to women of this age group should be undertaken only after weighing the possible risk to the fetus against the possible benefits to the mother. Teratogenic studies in two animal species have resulted in no abnormalities in the offspring.

Precautions
It is expected that patients on dextrothyroxine therapy will show greatly increased serum protein-bound-iodine levels. These increased serum PBI values are evidence of absorption and transport of the drug, and should NOT be interpreted as evidence of hypermetabolism; similarly, they may not be used for titrating the effective dose of CHOLOXIN (sodium dextrothyroxine). PBI values in the range of 10 to 25 mcg% in treated patients are common.

If signs or symptoms of iodism develop during CHOLOXIN therapy, the drug should be discontinued.

A few children with familial hypercholesterolemia have been treated with CHOLOXIN for periods of one year or longer with no adverse effects on growth. However, it is recommended that the drug be continued in patients in this age group only if a significant serum cholesterol-lowering effect is observed.

Adverse Reactions
The side effects attributed to dextrothyroxine therapy are, for the most part, due to increased metabolism, and may be minimized by following the recommended dosage schedule. Adverse effects are least commonly seen in euthyroid patients with no signs or symptoms of organic heart disease; the incidence of adverse effects is increased in hypothyroid patients, and is highest in those patients with organic heart disease superimposed on the hypothyroid state.

In the absence of known organic heart disease, some cardiac changes may be precipitated during sodium dextrothyroxine therapy. In addition to angina pectoris, arrhythmia consisting of extrasystoles, ectopic beats, or supraventricular tachycardia, ECG evidence of ischemic myocardial changes and increase in heart size have been observed. Myocardial infarctions, both fatal and non-fatal, have occurred, but these are not unexpected in untreated patients in the age groups studied. It is not known whether any of these infarcts were drug related.

Changes in clinical status that may be related to the metabolic action of the drug include the development of insomnia, nervousness, palpitations, tremors, loss of weight, lid lag, sweating, flushing, hyperthermia, hair loss, diuresis, and menstrual irregularities. Gastrointestinal complaints during therapy have included dyspepsia, nausea and vomiting, constipation, diarrhea, and decrease in appetite.

Other side effects reported to be associated with CHOLOXIN (sodium dextrothyroxine) therapy include the development of headache, changes in libido (increase or decrease), hoarseness, tinnitus, dizziness, peripheral edema, malaise, tiredness, visual disturbances, psychic changes, paresthesia, muscle pain, and various bizarre subjective complaints. Skin rashes, including a few which appeared to be due to iodism, and itching have been attributed to dextrothyroxine by some investigators. Gallstones have been discovered in occasional dextrothyroxine-treated patients and cholestatic jaundice has occurred in one patient, although its relationship to CHOLOXIN therapy was not established.

In several instances, the previously existing conditions of the patient appeared to continue or progress during the administration of CHOLOXIN; a worsening of peripheral vascular disease, sensorium, exophthalmos, and retinopathy have been reported.

CHOLOXIN potentiates the effects of anticoagulants, such as warfarin or Dicumarol, on prothrombin time, thus indicating a decrease in the dosage requirements of the anticoagulants. On the other hand, dosage requirements of antidiabetic drugs have been reported to be increased during dextrothyroxine therapy (see WARNINGS section).

Dosage and Administration
For **adult** euthyroid hypercholesterolemic patients, the recommended maintenance dose of CHOLOXIN (sodium dextrothyroxine) is 4 to 8 mg per day. The initial daily dose should be 1 to 2 mg to be increased in 1 to 2 mg increments at intervals of not less than one month to a maximum level of 4 to 8 mg daily, if that dosage level is indicated to effect the desired lowering of serum cholesterol.

When used as partial or complete substitution therapy for levothyroxine in hypothyroid patients with cardiac disease who cannot tolerate other types of thyroid medication, the initial daily dose should be 1 mg to be increased in 1 mg increments at intervals of not less than one month to a maximum level of 4 to 8 mg daily, preferably the lower dosage. The maximum in patients receiving digitalis therapy is 4 mg.

For **pediatric** hypercholesterolemic patients, the recommended maintenance dose of CHOLOXIN is approximately 0.1 mg per kilogram. The initial daily dosage should be approximately 0.05 mg per kilogram to be increased in up to 0.05 mg per kilogram increments at monthly intervals. The recommended maximal dose is 4 mg daily, if that dosage is indicated to effect the desired lowering of serum cholesterol.

If new signs or symptoms of cardiac disease develop during the treatment period, the drug should be withdrawn.

How Supplied
CHOLOXIN (sodium dextrothyroxine) is supplied in prescription packages of scored 1, 2, 4, and 6 mg tablets.

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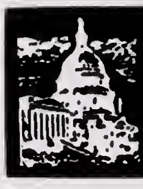

WASHINGTON

Congress deserted Washington for a summer holiday leaving behind not only the August heat of the Potomac swamplands but, also, most of its planned health legislation still hanging up in the humid air.

With passage of national health insurance (NHI) written off for this year, both the Senate and House on return will tackle a variety of health or health-related matters including health manpower, already passed by the House, amendments to the Health Maintenance Organizations Act (HMO) and possible changes to the Medicare law.

While the health subcommittee of the House Ways and Means Committee has scheduled public hearings on NHI for October 28, subcommittee chairman Daniel D. Rostenkowski (D-Ill.) stated "the considerable lead time needed to forge a NHI bill" as the unexpected reason for hearings this year.

Pressing problems with Medicare, however, have prompted Rep. Rostenkowski to schedule hearings on possible changes to that law on September 19.

"Recent oversight hearings concerned certain HEW regulations, including those on utilization review and the 8.5% nursing care differential. As we consider Medicare changes, I expect that we will explore the possibility of major modifications in the way hospitals are reimbursed. And we will look at how Medicare may help hospitals facing steep increases in malpractice insurance rates," Rep. Rostenkowski said.

The slating of an additional hearing indicates the subcommittee will probably draft legislation to change some of the present Medicare regulations. There may not be time for final Congressional action this year, but legislation could clear Congress next year.

Many of the revisions the subcommittee members are considering would be welcome to the medical profession.

Listed as one topic of the hearing was the present law's requirement that physicians' Medicare reimbursement be tied to a type of cost-of-living index and geared to the 75th percentile of normal and customary charges. The American Medical Association has challenged the fairness of HEW's proposed index and warned that the regulation could drive increasing numbers of physicians away from assig ment. Another hearing subject is "physicians' se vices reimbursement—possible basic changes i present 'reasonable charge' system."

Two other controversial Medicare regulations a up for review—possible revisions in Profession Standards Review Organizations (PSRO) pr visions and utilization review requirements for ho pitals, the latter under temporary injunction by th federal courts as a result of an AMA court protes

Other issues to be considered by the subcommi tee:

* Termination of the 8.5% nursing differential i hospital costs.

* Redefinition of reasonable cost level for ho pitals (90th to 80th percentile and revised hospit classification system).

* Nurse staffing requirements in rural hospita (authority to wave certain requirements with r spect to nurse staffing requirements in rural ho pitals expires on Jan. 1, 1976).

* Medicare relationship to Federal Employe Health Program (no payment may be made unde Medicare, beginning Jan. 1, 1976, for services pr vided to members of the Federal Employee Pla unless a system of coordination between two pr grams is developed under present law).

* Revisions in hemodialysis and kidney tran plant provision to improve administration and e hance cost effectiveness.

* Revisions in home health care provisions.

* Medicare Part B premium increase provision-correction of technical error in present law whic precludes increasing the premiums.

* Institutional services reimbursement—possibl basic changes from the present retroactive reason able cost reimbursement.

* Consideration of a specific proposal, with r spect to malpractice, to permit hospitals to self-in sure and charge such costs to Medicare.

* Revisions in current coverage of ambulanc services.

* Coverage of pap smears under Medicare Part E

* Possible charges in payment methods for physi cians' services when patient is deceased.

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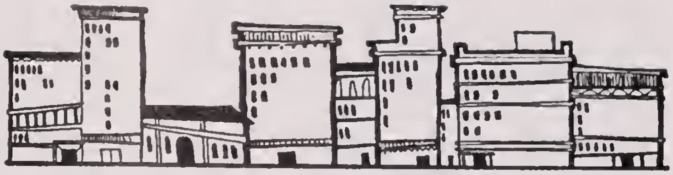

ASHINGTON UNIVERSITY

A new coronary rehabilitation program began n September 1 with the opening of an indoor ack at the School of Medicine. The track, which ; 1/26th mile in length and four lanes wide, is on e fifth level of the Irene Walter Johnson Institute f Rehabilitation. It will be used for jogging pro- rams, primarily for persons with heart disease.

Jon D. Cooksey, M.D., assistant professor of edicine and of preventive medicine and Associate edical Director of the Institute, will direct these rograms. Interested persons will be given an ex- mination to determine if they are physically cap- ble of exercising. Eligible participants will be put n individual exercise programs, according to their bilities.

The Brown-Hazen Program of the Research Cor- oration of America, Minneapolis, Minn. has re- ewed a $26,500 grant for postgraduate training nd research in fungus disease at Washington Uni- ersity School of Medicine.

George S. Kobayashi, Ph.D. and *Gerald Medoff,* .D., associate professors of medicine and assistant rofessors of microbiology, are codirecting the pro- ram which will train postdoctoral fellows in the tudy of fungi.

Dr. Medoff stated that this is one of the few raining programs in existence in mycology, and he $100,000 that has been received over the past hree years from the Brown-Hazen Fund has helped establish this unique program at Washington niversity.

Virginia V. Weldon, M.D., has been named As- istant to the Vice-Chancellor for Medical Affairs r Governmental Relations at the School of Med- cine.

Dr. Weldon will serve as a liaison between the edical center and various governmental agencies oncerned with medical affairs. This new position as created because of the increased interaction etween government and academic medical centers.

An associate professor of pediatrics and co-direc- r of the Division of Pediatric Endocrinology and etabolism, Dr. Weldon also is associate pediatri- ian to the St. Louis Children's Hospital, St. Louis aternity and McMillan Hospitals.

UNIVERSITY OF MISSOURI-COLUMBIA

There have been a number of changes among the faculty at the School of Medicine this fall. *Dr. Donald A. Senhauser* and *Dr. Paul A. Young* left during the summer to become department chairmen at other institutions. *Dr. Clement Brooke* and *Dr. Earl Kerr,* long-time faculty members in pediatrics and pathology, respectively, have retired, and some doctors have left to go into private practice or to teach at other medical schools.

Among the new faculty members are *Dr. Hedayatollah Elyassi* and *Dr. George A. Rofkar* in the Department of Anesthesiology. *Dr. Kenneth Keown,* who has held an administrative position in the Medical Center for several years, is returning full-time to the department, also.

Dr. Elyassi, who comes from the University of Chicago, has been appointed an associate professor and also will serve as medical director of the respiratory therapy curriculum.

Dr. Rofkar, assistant professor of anesthesiology, has been in private practice of anesthesia in Bellingham, Wash., for the past six years.

Dr. Charles W. Sisk is a new associate professor in the Department of Medicine.

Dr. Sisk was on the Kansas University faculty in the Department of Preventive Medicine from 1966 to 1968, when he went to Washington on the staff of the director of Regional Medical Programs, Department of Health Services and Mental Health Administration.

Dr. Mehdi Farhangi, associate professor of medicine, has come to Missouri from Presbyterian Hospital and Columbia University, New York City. A specialist in hematology, he has held faculty positions in both pathology and medicine at Columbia's College of Physicians and Surgeons.

Dr. Michael C. Perry, also a hematologist, has recently completed five years of training at Mayo Graduate School of Medicine. He has been appointed assistant professor of medicine and also will be in the medical oncology group.

Dr. John H. Bauer, assistant professor of medicine, has completed postdoctoral work in nephrology and hypertension at Indiana University Medical Center, where he also took his residency training.

Dr. Lawrence Alan Callaway, a 1967 graduate of the University of Missouri School of Medicine, is returning to Columbia as an assistant professor in the Department of Pathology. He has been chief resident in pathology at St. John's Mercy Medical Center in St. Louis.

Dr. Ira Weinstein, associate professor of pharmacology, has been on the faculty at the University of Florida School of Medicine since 1969.

Dr. Agnes H. Moon and *Dr. Leon K. Rittenhouse* have recently joined the faculty of the Department of Physical Medicine and Rehabilitation. Dr. Moon came in June from Strong Memorial Hospital, University of Rochester, N. Y. Dr. Rittenhouse previously had been chief of rehabilitation medicine service at a VA Hospital in Pennsylvania and in private practice.

ST. LOUIS UNIVERSITY

Dr. Theodore A. Cooper, assistant secretary for health, U. S. Department of Health, Education and Welfare, returned to his alma mater to deliver the keynote address at groundbreaking ceremonies which marked the construction of a three-level St. Louis University Medical Center Learning Resource Center on July 25. Dr. George E. Thoma, vice-president for the Medical Center, was master of ceremonies.

The new facility, a multipurpose educational building, will adjoin the Caroline Building. It link with the St. Louis University School of Medicine.

Dr. Cooper earned both his M.D. degree (1954 and Ph.D. degree in Physiology (1956) at St. Loui University. He is a former professor of surgery o the St. Louis University School of Medicine facult Mrs. Cooper is a 1956 graduate of the Universit School of Nursing. Their son, Michael, will enrol at St. Louis University in September.

In addressing the record crowd attending th ceremonies, Dr. Cooper said, "I am delighted t join with you in these groundbreaking ceremonie not least because it gives me a welcome opportunit to return to the University where I spent many enjoyable years, some of them, I seem to recall, in th Medical Library."

The new Learning Resource Center is funded b a $6,639,469 grant awarded to the School of Medicine by the Department of Health, Education an Welfare for construction of the Learning Resourc Center and completion of renovations to the Schoo of Medicine. The federal grant is funding 70% o the total project, while the other 30% is being raise by the University.

The new Center will contain a 580-seat auditorium which can be converted into three smalle auditoriums, clinical simulation laboratories, a multi-media audiovisual center with the latest television equipment and conference and study areas.

The Center will be connected to the School o Medicine at the lower level and at the second leve of the new structure.

The library, which will be suspended from th roof, was designed with open spaces for study under a skylighted area.

The first floor of the building will house the uppe half of the tiers of seats of a sloping auditorium. Around the periphery of the auditorium will be th new continuing education department offices and conference rooms, classrooms and seminar space.

The lower level of the Center will contain th lower half of the auditorium, the clinical simulation areas and three separate student reading areas which will be open 24 hours a day.

Expected completion date of the project is November, 1976.

Renovations within the School of Medicine, funded by the federal grant, will include renovation of the student cafeteria in the School's basement, a modernized book store and plant department.

Other renovations will take place in the administrative area of the second floor and in the departments of Anatomy, Biochemistry, Pharmacology and Pathology.

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Continuing Education Coming Events

Sept. 26	**Symposium: Clinical Allergy for Practicing Physicians** Continuing Medical Education Erlanger Auditorium Washington U. School of Medicine, St. Louis
Sept. 26-27	**The Long Weekend: Therapeutics of Cardiac Arrhythmias and Emergency Care Workshop** MU-KC School of Medicine, K.C. Southwest Clinical Society and Academy of Health Professions MU-KC School of Medicine, Kansas City
Sept. 26-27	**Symposium: Early Management of Thermal Injuries** American Burn Association and K.U. School of Medicine Crown Center Hotel, Kansas City
Oct. 1	**Seminar: Congestive Heart Failure** The Ed Bixby Institute for Postgraduate Medical Education Research Medical Center, Kansas City
Oct. 1 & 8	**Seminars in Noninvasive Cardiology: Electrocardiography** Depts. of Medicine and Radiology, St. Luke's Hospital and Washington U. Continuing Medical Education St. Luke's Hospital, St. Louis
Oct. 9-10	**Seminar: Pulmonary Diseases and Infectious Diseases of the Chest** Danciger Institute for the Health Sciences Menorah Medical Center, Kansas City
Oct. 13	**City-Wide Radiology Conference: Pharmacological and Air Contrast Studies in Gastrointestinal Tract** Mallinckrodt Institute of Radiology Washington U. School of Medicine, St. Louis
Oct. 23-25	**53rd Annual Fall Clinical Conference** Kansas City Southwest Clinical Society Crown Center Hotel, Kansas City
Oct. 23-25	**Oncology—Current Concepts and Future Prospects** Division of Hematology and Oncology and Continuing Medical Education Washington U. School of Medicine, St. Louis
Nov. 5-7	**Clinical Advances in Pediatrics** Postgraduate Education, Menorah Medical Center The Children's Mercy Hospital, Kansas City
Nov. 10	**City-Wide Radiology Conference: Newer Approaches in Ultrasound** Mallinckrodt Institute of Radiology Washington U. School of Medicine, St. Louis

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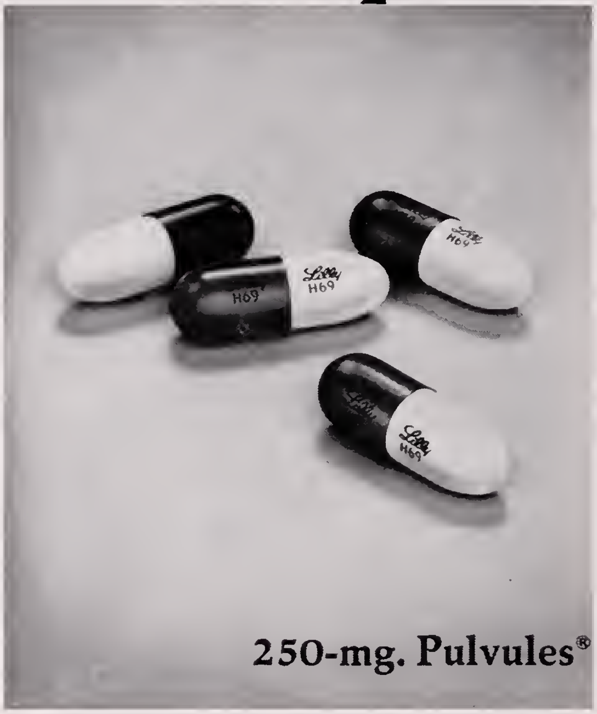
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CHARLES B. ANDERSON, M.D., *St. Louis*

Autotransfusion in Traumatic Hemothorax

HE PRINCIPLE OF AUTOTRANSFUSION has been estab-
shed for many years. It is generally regarded to
e an effective and safe method of volume restora-
on under a variety of circumstances.[1] Since High-
ore first suggested autotransfusion in 1874[2] and
uncan's actual employment of intraoperative
utotransfusion in a patient with a traumatic leg
mputation in 1885,[3] there has been a vacillating
terest in autotransfusion. This method of blood
eplacement has been employed most frequently
n ruptured ectopic pregnancy. However, its use
lso has been described in splenic rupture, trau-
atic hemothorax, amputations, abdominal injury,
lacenta praevia, urological procedures, stab
ounds of the heart and neurosurgical procedures.

In more than 1,000 documented cases of auto-
ansfusion, there have been only infrequent ma-
r complications directly attributed to the proce-
ure. [1, 4] Only four fatalities are mentioned in the
terature and each occurred either when the blood
hat was used had been present in the abdominal
avity more than three days[5] or when faulty filtra-
ion permitted venous embolization to the lungs.

A variety of methods and devices have been ad-
ocated for use in autotransfusion.[1, 6–10] Proce-
ures have varied from simple ladling or sponging
f blood from a serous cavity followed by filter-
ng clots and reinfusion to the use of complicated
quipment involving the simultaneous aspiration
nd reinfusion of blood which requires continu-
us monitoring of the equipment.[9]

Traumatic hemothorax presents a unique situa-
ion which permits easy access to a usable source of
lood. There are relatively few reports in the lit-
rature dealing specifically with autotransfusion for traumatic hemothorax.[10] The earliest mention of this subject was by Elmendorf in 1917.[11] He aspirated 300 ml of blood from the pleural cavity of a wounded German soldier and reinfused it into a peripheral arm vein with immediate improvement and ultimate recovery of the patient. Also in 1917, Wederhake[12] reported successful results of autotransfusion in several cases of hemothorax due to gunshot wounds of the chest. In 1931, Brown and Debenham[13] described, for the first time in the United States, three cases of hemothorax, all of which were treated successfully by autotransfusion. In 1936, Watson and Watson[14] were the first to report autotransfusion during a thoractomy for a penetrating wound of the heart. In 1943, Griswold and Ortner[15] described 19 cases of autotransfusion in hemothoraces due to penetrating trauma. Ferrara,[8] in 1957, advocated autotransfusion in chest injuries accompanied by hemothorax and described in detail a method of

Although the potential value of autotransfusing blood in patients with traumatic hemothorax is not generally appreciated, the author concludes that this procedure is a valuable method of management when there is a need for rapid blood volume restoration. The significant advantages of autotransfusion are enumerated and an experience with 14 patients is reported. Dr. Anderson is from the Department of Surgery, Washington University School of Medicine and the Max C. Starkloff Memorial Hospital (City Hospital).

aspirating the blood with the use of a blood donor vacuum bottle containing citrate solution. Eight years later in 1965, Kharoshko[16] wrote about blood reinfusion in thoracic injuries.

Recently, Symbas and associates[10, 17] advocated autotransfusion in traumatic hemothorax and recommended the use of a large thoracostomy tube to facilitate drainage of blood. They performed detailed studies in 11 patients and demonstrated a decrease in fibrinogen, platelets and hematocrit of the collected blood. Cultures of blood prior to reinfusion were persistantly negative. Repeated venous blood samples revealed no rise in free plasma hemoglobin. They found no deleterious side effects of this treatment method.

Clinical Material and Methods

Fourteen patients ranging in age from 14 to 75 years and with traumatic hemothoraces were treated with tube thoracostomy and autotransfusion. There were seven low velocity gunshot wounds, one shotgun wound, four stab wounds and two blunt injuries of the chest. All patients were hypotensive on admission and six were moribund. Three cases had perforations of the diaphragm. In two of these cases, there were associated injuries to the gastrointestinal tract which were repaired at celiotomy. All patients needed rapid blood volume restoration. Resuscitative measures on admission included insertion of a central venous press line, fluid replacement, nasogastric intubation, sertion of a urinary catheter, endotracheal intub tion, assisted ventilation when indicated and ins tion of a # 36 Fr plastic Argyle chest tube in o or both pleural spaces. In several cases, two tu were placed on the same side to improve draina of the pleural space and to reexpand the lu Thoracostomy tubes were attached to presteriliz disposable chest bottles which were maintain under 15 cm H_2O suction and contained 300 ml sterile normal saline solution and 1000 units heparin. With this arrangement (Fig. 1A), blo rapidly drained into the chest bottle. Within a f minutes, the maximum available blood was c lected (in the absence of continued bleeding) a a second sterile chest bottle set-up was then changed for the first.

To facilitate attachment of a blood administ tion set to the chest bottle, a sterile double-end tapered plastic connection is used. The excess tu ing which has been painted with betadine to insu sterility is cut off (Fig. 1B). The connector is i serted into the vent opening (Fig. 2A) and a blo administration set snugly fitted into the connect (Fig. 2B).

Three different blood administration sets ha

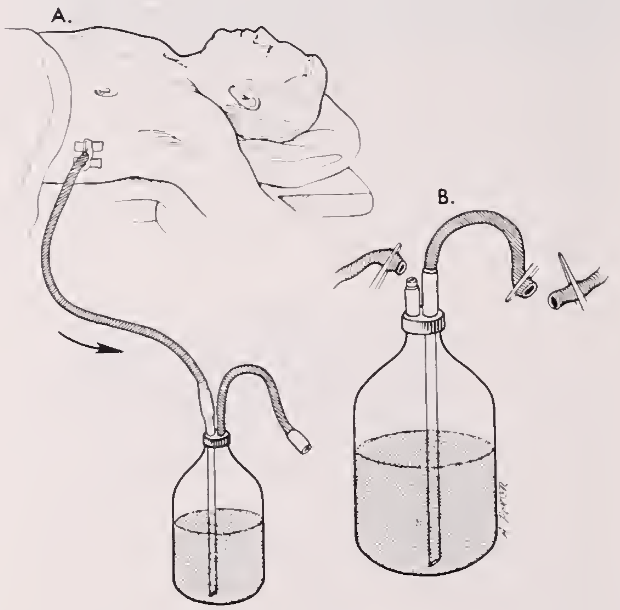

Fig. 1 (A) Blood from the pleural space is collected in a sterile chest bottle containing 300 ml of sterile saline and 1,000 units of heparin. (B) After disconnecting the chest bottle from the thoracostomy tube, the tubing is painted with an antiseptic solution and the excess cut off.

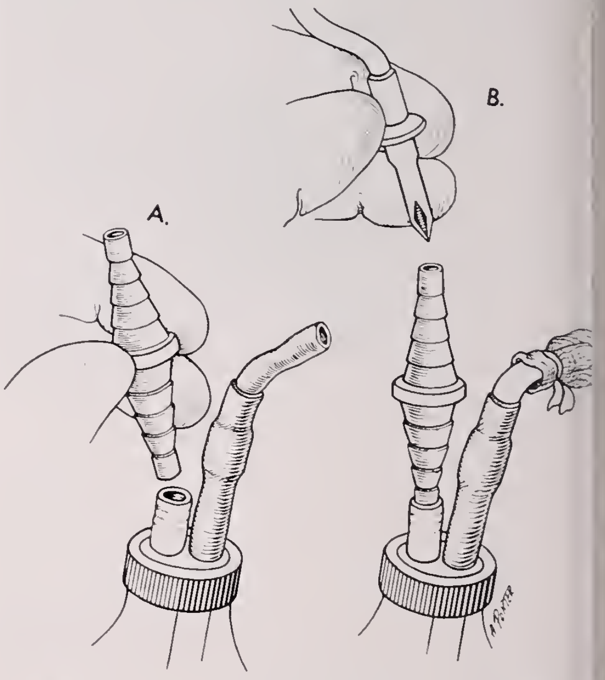

Fig. 2 (A) A sterile, double-ended tapered connect is inserted into the vent opening of the chest bottle. (The blood-administration set snugly fits into the connect and the tubing which was previously connected to the patie is covered with a sterile gauze to prevent aspiration material when the bottle is inverted.

een used, and each easily attaches to the plastic onnector. The bottle is turned upside down and he inlet side, which was previously connected to he chest tube, now becomes the vent. Tape is applied to the bottle to facilitate suspension from an ntravenous (IV) standard and the blood is administered to the patient (Fig. 3). The usual blood adninistration set has proven to be satisfactory and as not required changing during the infusion as here are usually no clots present in the collected lood. On one occasion, clots were pulled from he pleural space into the collecting chest bottle beause of excessive suction applied to the chest bote. This problem was circumvented by straining he blood through six layers of 4 in. x 4 in. gauze rior to reinfusion.

ESULTS

Of the 14 patients treated by this method, three ied of shock in less than 48 hours. All three were noribund on admission, having sustained lethal inries of the heart, pulmonary artery or liver. owever, the immediate autotransfusion of 1,000 nl, 1,200 ml and 1,500 ml in these cases resulted in levation of the blood pressure and permitted time attempt operative repair of the injuries. Of the 1 patients who survived more than 48 hours, two esponded to autotransfusions of 550 ml and 1,500 nl of blood, respectively, and required no addiional blood transfusions. The nine remaining paients required additional infusions of from 500 6,000 ml of banked blood for adequate resusciation after receiving an average of 1,000 ml of utotransfused blood.

There were no adverse reactions noted in any of he patients which could be attributed to autoransfusion. Pulmonary emboli did not occur in ny of the surviving patients and were not found n postmortem examination in those who died. emoglobinuria was not observed, and there were o septic episodes or positive blood cultures in the ostoperative period. All of the cultures taken rom the chest bottles at the end of autotransfuion showed no growth.

ISCUSSION

Our initial interest in the autotransfusion of paients with traumatic hemothoraces stemmed from he critical condition of some patients and our villingness to attempt any reasonable method of esuscitation. Consequently, autotransfusion was t first used only in those individuals who were noribund on admission. Because of a satisfactory response in these patients and supportive evidence in the literature that autotransfusion in traumatic hemothorax is a safe and effective treatment, indications for reinfusing pleural blood now include all patients with hypotension on the basis of blood loss who have more than 500 ml of blood collected from the chest. It must be stressed, however, that in the majority of patients with traumatic hemothorax, bleeding into the chest will often be less than 500 ml and will usually stop, especially after insertion of chest tubes and reexpansion of the lung. In the absence of shock, blood from the hemothorax is still collected into heparinized sterile chest bottles and then stored at 4 C in the event that hypotension and further bleeding supervene.

Often, traumatic hemothorax is associated with

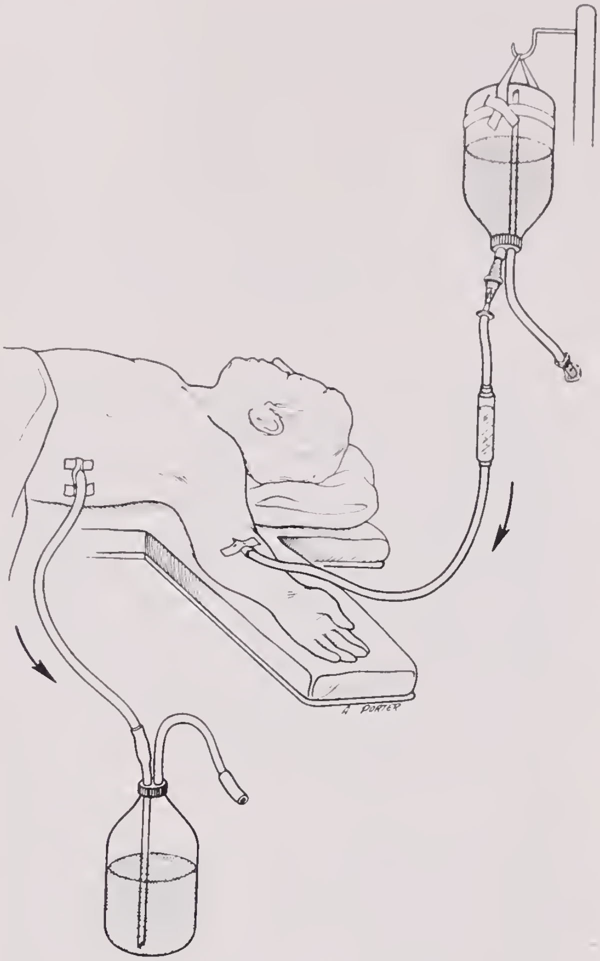

Fig. 3 The chest bottle is inverted and tape is applied to facilitate suspension from an IV standard. Blood is being infused by gravity into the patient's arm after filtration through a standard blood administration set. A second chest bottle, prepared with heparin and saline, is connected to the thoracostomy tube to collect any additional blood loss.

other sources of blood loss such as intraabdominal trauma and fractures of the extremities, and autotransfusion of relatively small amounts (300 ml to 500 ml) of blood recovered from the chest can be of benefit in partially expanding a depleted blood volume. Autotransfusion alone may be sufficient to reverse shock, in which case, the use of bank blood and all its attendant complications can be avoided. Obviously, gross contamination of the pleural space is a contraindication to autotransfusion.

Approximately 177 cases of autotransfusion for hemothorax have been mentioned in the English literature.[8-10, 14, 15] Symbas *et al*[10] were the first to emphasize the use of a large thoracostomy tube and to test the practical nature of such an approach on a large scale. However, the importance of this procedure, the improvement in connecting the blood administration set to the chest bottle via a double ended tapered connector and the paucity of recent reports concerning this practical and useful technique seem to require reemphasis of autotransfusion in traumatic hemothorax.

Any emergency facility capable of placing chest tubes can adapt the procedure of autotransfusion in traumatic hemothorax. In some areas without readily available blood bank capabilites, this may be the only practical source of emergency blood replacement. Minor modifications of the drainage and infusion setup may be necessary depending on the type of equipment available. Other methods of collecting and reinfusing blood have included thoracentesis (a slow and tedious procedure), blood donor vacuum bottles and continuous collection with reinfusion by roller pumps. The use of blood donor vacuum bottles is generally unsatisfactory for collecting pleural blood because of the high suction applied to the pleural space.

Klebanoff[9] has recently championed the use of a disposable autotransfusion unit with roller pumps for suction and reinfusion. To apply this method of autotransfusion in a patient with a traumatic hemothorax and who does not require thoracotomy seems unduly cumbersome. If thoracotomy is necessary to secure hemostasis, then this intraoperative method of continuous aspiration and infusion of autologous blood under systemic heparinization may be of value. A large majority of community hospitals do not have the equipment or personnel necessary to use this technique and, therefore, a simple method of autotransfusion is desirable.

The disadvantages of autotransfusion in traumatic hemothorax are few and mostly theoretica There could be found no reports in the literatur of pulmonary embolism, sepsis, allergic reactior or significant hemoglobinuria or hemoglobinemi in association with transfusing blood from acut traumatic hemothoraces. On the other hand, th advantages of this procedure include the follow ing:

1. A simple method readily adapted for us in any emergency room.
2. Immediate availability of blood, even wit rare blood types.
3. Cross matching blood not required and n transfusion reactions.
4. No risk of hepatitis, syphilis or other bloo transmittable diseases.
5. No allergic reactions.
6. Warm blood.
7. Inexpensive—no cost of collecting, process ing or matching donor blood.
8. Acceptable to Jehovah's Witness patient if immediately reinfused.[18, 19]
9. Normal half-life survival of red bloo cells[10, 20] and, perhaps, less hemolysis than wit banked blood.
10. No immunological sensitization by allo transfused leukocytes and platelets.[21]
11. Less risk of overtransfusion.
12. Relatively normal acid-base characteristic of blood.
13. Avoids citrate in rapid blood infusions i hypotensive patients.
14. Normal hemoglobin—oxygen dissociatio characteristics of blood.

Autotransfusion in patients with traumatic he mothorax is a proven and valuable method o management which has not been widely appreciat ed. This procedure has the potential of becomin a significant advancement in the treatment of th properly selected individual with a hemothora and hypotension due to blood loss. Indeed, thi source of blood should be used in preference t stored, banked-blood whenever the need for whol blood administration exists.

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WILLIAM J. OTT, M.D. *and*
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iagnostic Laparoscopy in a niversity Training Program

Case Reports

The authors review 114 cases in which diagnostic laparoscopy was utilized in a five-year period and summarize certain complications. Emphasis is placed on proper placement of the needle for pneumoperitoneum. A report of a case of bilateral pneumothorax is included. Dr. Ott and Dr. Woods are from the Department of Gynecology and Obstetrics, St. Louis University School of Medicine.

RECENT YEARS, laparoscopy has become an in- easingly utilized tool of the modern gynecologist r many diagnostic and surgical procedures. Many cellent review articles reviewing the history and plications of the laparoscope have appeared in e last few years.[1–4]

The real impetus in laparoscopy began in the rly 1960s when Steptoe and others began pub- hing the reports of the use of laparoscopy for lateral sterilization.[5, 6] While the laparoscope's eatest use is for sterilization, diagnostic laparos- py remains an important tool in the armamen- rium of the gynecologist.

ATERIAL AND METHODS

The cases discussed in this paper were selected om laparoscopies done during a five-year period an. 1, 1969 until Dec. 31, 1973) at St. Louis City spital and Firmin Desloge Hospital.

The technique used is as follows:

With the patient under general anesthesia with cheal intubation, a stab incision is made in the dline through the skin in the lower margin of e umbilicus with a # 10 blade. Through this inci- n, a Verres needle with the valve closed is intro- ced in a sagittal plane at a 45-degree angle to e vertical and directed toward the pelvis until e feeling of puncturing the rectus fascia or ea alba is felt. The needle is then changed to a re vertical direction and advanced slightly until is felt that the peritoneal cavity has been en- ed.

A drop of saline is placed in the hub of the rres needle and the valve is opened. If the line is sucked into the needle, this is taken as esumptive evidence that the needle tip is free in e peritoneal cavity. A 10 cc syringe filled with line is then attached to the hub of the needle d the saline is injected and then aspirated. If no line is obtained on aspiration, this is again taken as evidence that the needle is free in the peritoneal cavity.

Since automatic insufflation equipment was not available at the two hospitals during the time of the present study, direct delivery of the gas by catheter from an anesthetic machine at low pressure was utilized to effect the pneumoperitoneum. Initially, a pressure monometer was connected through a three-way stop cock and intraperitoneal gas pressure was measured. Because of technical problems, however, this was discontinued and adequacy of the pneumoperitoneum was evaluated on clinical grounds alone.

CO_2 was initially used but N_2O was substituted because of the resulting hypercarbia and tachypnea. This has proven to be satisfactory to anesthetists as well as clinicians.

The patient then is placed in an approximately 15-degree Trendelenburg position. After an adequate pneumoperitoneum has been obtained, the Verres needle is removed and the trocar and sleeve for the laparoscope is introduced in the following fashion:

The skin at each edge of the subumbilical incision is grasped with large towel clips and elevated; the trocar is then inserted into the peritoneal cavity, directed toward the pelvis, in the sagittal plane at an angle of 45% to the vertical. The laparoscopes used in the study were manufactured with a 10 ml diameter and a 180-degree lens.

Transillumination of the anterior abdominal wall with the laparoscope allows selection of an avascular site for the introduction of the second trocar under direct vision, either in the midline or in either of the lower quadrants.

During the five-year period mentioned, a total of 114 diagnostic laparoscopy cases were available for study through the record rooms at the two ho pitals. Forty-one procedures were done at City Ho pital and 73 at Firmin Desloge Hospital.

TABLE 1

	City	*FDH*	*Total*
Number of cases	41	73	114
Age	8-52 (23.5)	14-54 (23.4)	8-54 (23.4)
Indications			
Chronic pain	9	18	27
Rule out ectopic	17	16	33
Pelvic mass	9	6	15
Infertility	6	9	15
Endocrine evaluation	3	17	20
Endometriosis	0	1	1
Anasarca	0	1	1

TABLE 2

FINDINGS ON LAPAROSCOPY

	City	*FDH*	*Total*
Ectopic pregnancy	2	3	5
Functional ovarian cyst	4	10	14
Mass requiring operation	6	3	9
Stein-Leventhal ovaries	3	10	13
Normal findings	9	14	23
Pelvic inflammatory disease	12	12	24
Congestion (broad ligament tear)	3	6	9
Inadequate examination	3	2	5
Failed laparoscopy	2	3	5
Other	0	11	11*

* See Table 3.

TABLE 3

OTHER FINDINGS AT LAPAROSCOPY

No.	*Findings*
1	Streak ovaries—absence of uterus, tubes and vagina
1	Premature menopause—small ovari
3	Endometriosis
1	Cirrhosis of liver
1	Gonadal dysgenesis
3	Intrauterine pregnancy*
1	Small uterus with one streaked ovary, one normal ovary

* 2 normal deliveries at term. 1 abortion—3½ weeks later.

Results

Table 1 gives a summary of the number (laparoscopies performed at each hospital, listir the age distribution of the patients with a mea of 23.5 years and the various indications for la aroscopy. Evaluation of chronic pelvic pain, eva uation of adnexal masses and to rule out ectop pregnancy, evaluation of infertility and evalu tion of endocrine status were the most common i dications for laparoscopic examination.

Tables 2 and 3 show the various findings at tin

TABLE 4

LAPAROSCOPY REQUIRING LAPAROTOMY

	City	*FDH*	*Total*
No. (%)	12 (29%)	25 (34%)	37 (32%
Type			
Ovarian cystectomy	2	4	6
Tumor removal	1	1	2
Ectopic	2	3	5
Wedge resection	0	4	4
Plication and suspension	3	2	5
Removal of tubo-ovarian abscess	4	0	4
Total abdominal hysterectomy and bilateral salpingo-oophorectomy	0	4*	4
Removal of streak ovaries	0	1	1
Liver biopsy	0	1	1
Inadequate examination requiring laparotomy	0	3	3
Compication of laparoscopy	0	2	2

* 2—PID. 2—broad ligament tear.

TABLE 5

COMPLICATIONS

	No.	*Type*	%
City	3	Bilateral pneumothorax "Arrest"* Infection	7.
FDH	3	Gas in mesentery Retroperitoneal hemorrhaging Left sided pneumothorax	3.
Total	6		5.

* Unexplained drop in pulse and blood pressure neces sitating termination of the procedure.

laparoscopy. Table 4 indicates the number of aroscopies that required further surgical proce- res following the laparoscopy. Approximately % of the patients did require a further surgical ocedure after laparoscopic diagnosis.

Major complications associated with the laparo- opic procedures are listed in Table 5. The major mplication rate was 5.3%. Most of the complica- ns seemed to be associated with the introduction a pneumoperitoneum. The following three ses illustrate complications that can arise from lure to secure an adequate pneumoperitoneum.

SE REPORTS

Case # 1. A 23-year-old, white woman, Gravida 0, ra 0, had been treated by various physicians since age of 16 because of primary amenorrhea and fail- of primary sexual development. She had been ated with various hormonal therapies and had under- ne periodic evaluation in the past. She was admitted Firmin Desloge Hospital on March 31, 1971 for aluation of her endocrine status. She underwent diag- stic laparoscopy on April 1, 1971.

At the time of laparoscopy, the Verres needle was erted midway between the symphysis pubis and ibilicus. There was some difficulty noted in introduc- the Verres needle and when the pneumoperitoneum s attempted with the nitrous oxide, subcutaneous physema was noted. However, it was felt that an equate pneumoperitoneum had been obtained. The car for the laparoscope was introduced through the Verres needle site. Upon inspection, it was found that the trocar had been introduced into the bladder and the nitrous oxide had been introduced into the paravesical space. It was decided at that time to treat the complication conservatively by introducing a Foley catheter into the bladder and to proceed with the laparoscopy. The Verres needle and cannula were then reinserted via a subumbilical incision and diagnostic laparoscopy was performed with adequate visualization of the pelvic contents. The diagnosis of bilateral streaked ovaries with a small uterus and tube were made. The patient had a chest x-ray while on the table after the examination, and it was felt to be within normal limits.

The patient's postoperative course was complicated by temperature elevation to 102 F. An abdominal X-ray taken two days after the laparoscopy showed an unusual gas pattern superimposed in the pelvis suggesting an abscess (Fig. 1). An intravenous pyelogram (IVP) showed a deformity of the bladder secondary to the gas in the paravesical tissues but, otherwise, was within normal limits (Fig. 2). The patient continued to run a febrile course and, also, showed some signs of pulmonary atelectasis and infiltration in her chest x-ray taken on the second postoperative day. Treatment was begun with kanamycin sulfate (Kantrex) and ampicillin. By the fourth postoperative day, the patient had become afebrile and continued to improve markedly. She was discharged on April 9, 1971 with a diagnosis of ovarian dysgenesis and chemical peritonitis due to nitrous oxide introduced at time of laparoscopy.

Case # 2. A 27-year-old, white woman, Gravida 1, Para 1, was admitted on April 6, 1971 to Firmin Desloge Hospital with a diagnosis of chronic abdomi-

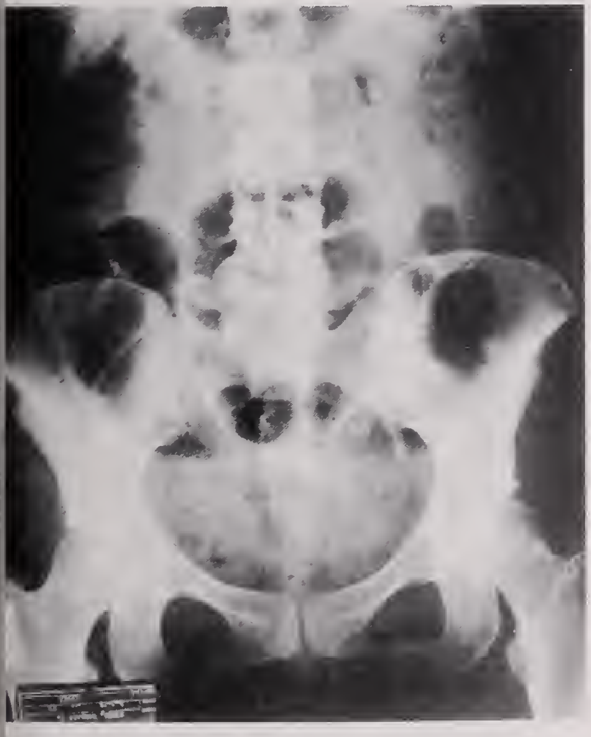


Fig. 1 Abnormal gas pattern in the pelvis suggests an scess (Case # 1).

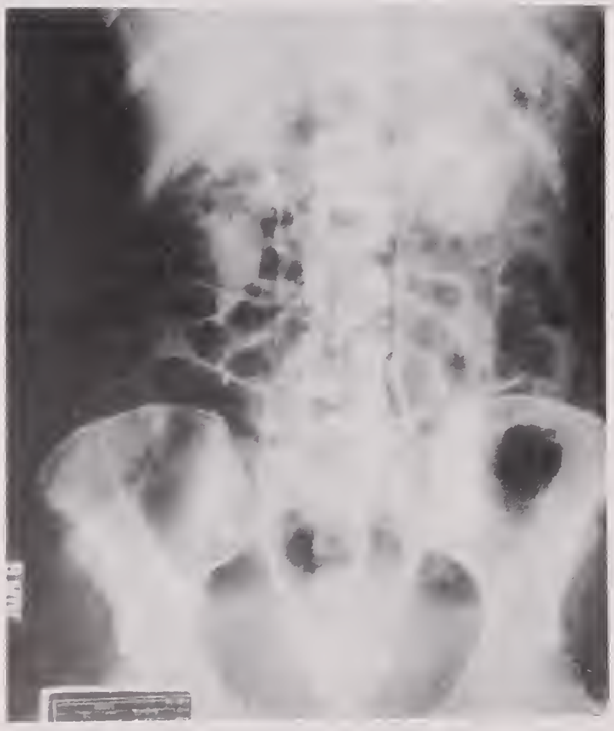


Fig. 2 Normal intravenous pylogram with gas pattern still present (Case # 1).

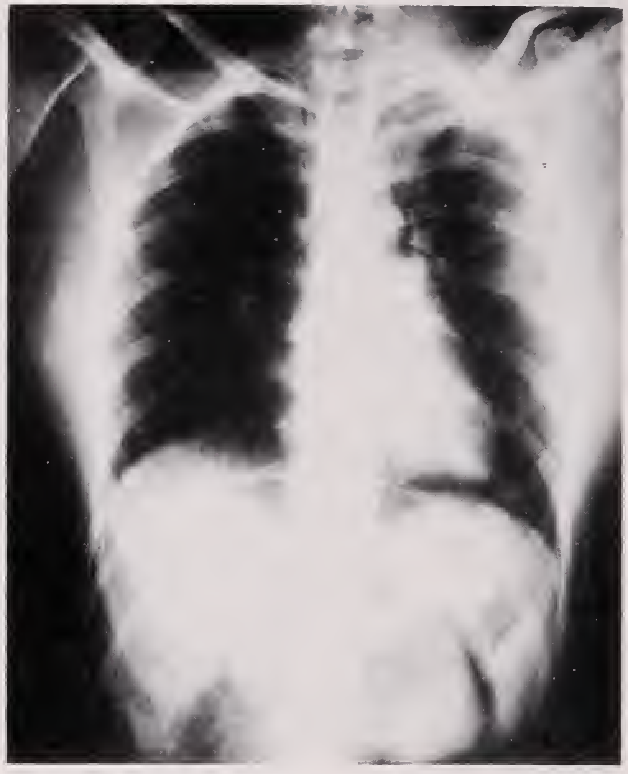


Fig. 3 Marked mediastinal emphysema and small pneumothorax are on the left. Free air also is seen under the diaphragm (Case # 2).

nal pain. On April 8, 1971, she underwent diagnostic laparoscopy using a subumbilical site for introduction of the Verres needle. Upon attempting to introduce the cannula of the laparoscope, it was noted that subfascial and subcutaneous emphysema had developed. At this time, it was decided to proceed with a laparotomy. Bilateral broad ligament laceration and pelvic varicosities were noted, a broad ligament repair and uterine suspension were done. During the operative procedure, subcutaneous emphysema and crepitus in the anterior costal margins were noted, but the patient's vital signs remained stable. The patient tolerated the operative procedure well and was taken back to the recovery room.

A portable chest x-ray was taken in the recovery room to evaluate the persistent subcutaneous emphysema. It revealed a pneumothorax on the left with a 1 cm separation of the visceral and parietal pleura (Fig. 3). A pneumomediastinum was noted and free intraperitoneal air was seen along with subcutaneous emphysema in the neck. Since the patient was in no distress and showed no signs of respiratory depression, it was decided to treat her expectantly and, therefore, chest tubes were not placed. A chest x-ray on the following morning revealed minimal free air beneath the left hemidiaphragm and minimal free air along the left heart border. The left lung appeared completely aerated and there was no evidence of pneumothorax present.

Case # 3. A 27-year-old, black woman, Gravida 1, Para, 0, Aborta 1 who had been evaluated for a number of months for infertility in the outpatient clinic St. Louis City Hospital. The patient was admitted St. Louis City Hospital on Oct. 23, 1973 for lapar scopic evaluation of pelvic organs and tubal patenc which was attempted on Oct. 25, 1973.

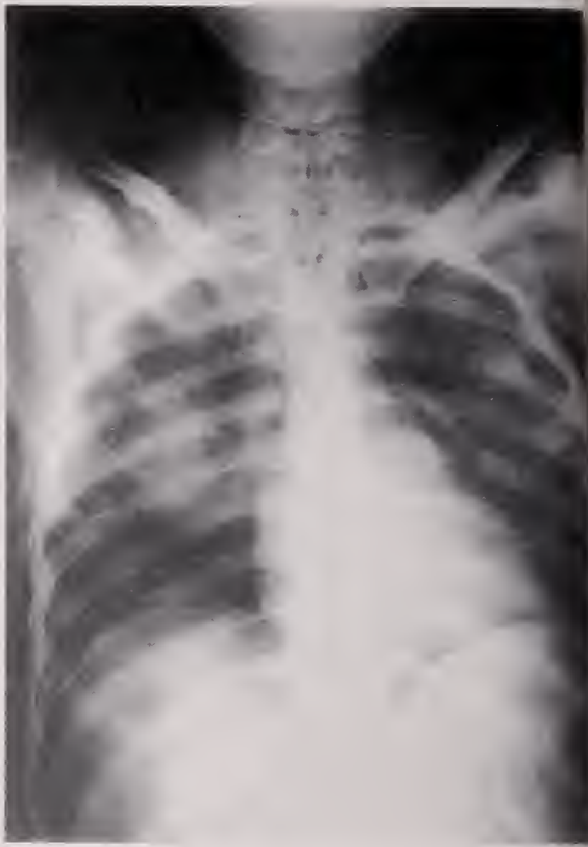
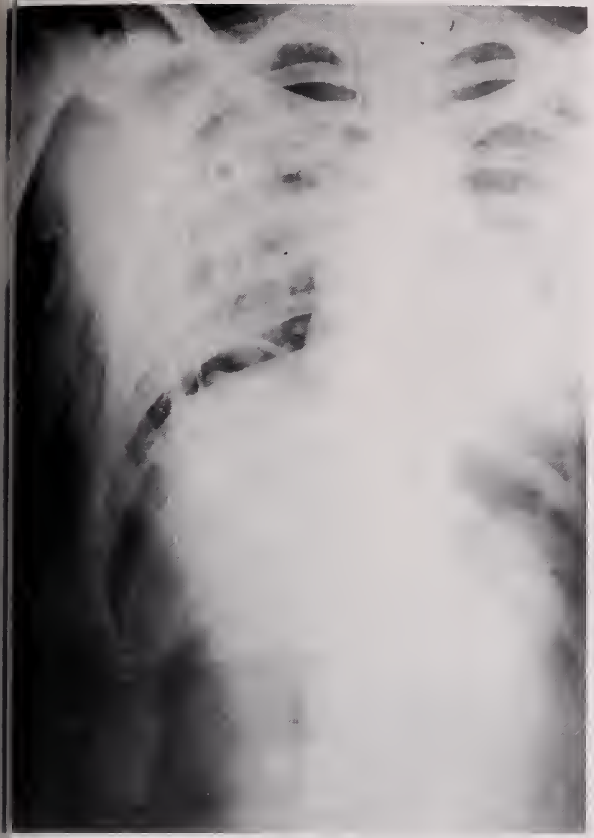


Fig. 4 Bilateral pneumothorax (Case # 3).

The patient was placed in lithotomy position and #12 Foley catheter was introduced into the uteri cavity and the bulb was inflated. The Verres need was introduced through a stab incision in the low border of the umbilicus and was thought to have be placed in the peritoneal cavity. Approximately 4 lite of nitrous oxide was introduced through the needl About one minute after beginning the introduction the nitrous oxide, subcutaneous emphysema was not in the neck and the anesthetist complained of difficul in ventilating the patient. The procedure was term nated and a portable chest x-ray was obtained (Fig. This showed the presence of gas in the peritone cavity, retroperitoneally, and in the tissues of t thorax, mediastinum and both pleural cavities. T endotracheal tube was in normal position. Diagnoses bilateral pneumothorax, mediastinal emphysema a pneumoperitoneum were made. After a surgical cons tation, it was decided to place chest tubes into bo pleural cavities while the patient was still under an thesia. An x-ray taken after chest tubes had be inserted showed them to be in the proper positio (Fig. 5). A chest x-ray obtained on the day followi the operation showed scattered atelectasis and possib pneumothorax on the right. The patient was treat



ig. 5 After insertion of bilateral chest tubes (Case 3).

h chest tubes for two days. The tubes were then noved and no further studies in regard to her ertility were performed.

SCUSSION

Numerous cases of complications from both op- ative and diagnostic laparoscopy have been re- rted in the literature in recent years.[7-12]

In a recent article on the state of the art of aroscopy, Phillips, Keith and Keith report vari- s complications associated with the procedure.[4] e most common complication seems to be subcu- neous emphysema. Most complications seem to associated with (1) the introduction of the edle for the pneumoperitoneum, (2) the intro- ction of the trocar of the laparoscope and (3) ermal injuries. In purely diagnostic procedures, is last complication would not occur.

The value of diagnostic laparoscopy in cases of certain pelvic pathology is becoming increasing- recognized as more and more procedures are ing done. Incidence of major complications asso- ted with laparoscopy vary from 1% to 20% with ny series stating only 2% to 4% complication te.[4, 7-14] The major complication rate of the combined series was 5.3% (7.3% at City Hospital and 3.2% at Firmin Desloge).

Most of the complications in our series of cases were directly related to unsatisfactory pneumoperitoneum. Improper placement of the insufflating gas can cause one of the most serious complications associated with laparoscopy. Doctor and Hussain reviewed the literature of pneumothorax associated with laparoscopy in 1973 and added one more case to the literature.[15] Smiler and Falick also recently reported an additional case.[16] Wadhwa and McKenzie reviewed the European literature and added 18 cases.[17] The two cases reported in this paper, if added to the literature, make a total of 28 reported cases of pneumothorax associated with laparoscopy.

Various theories have been developed for the causes of pneumothorax.[15, 18] They include (1) diaphragmatic hernia, (2) defects in the diaphragm or (3) subcutaneous emphysema dissecting around the tracheal tree and rupturing from the mediastinum into the pleural cavity. A fourth theory also can be postulated.

The space between the parietal pleural and the lateral chest wall usually is composed of loose connective tissue. This space can be either densely adherent to the chest wall or loosely connected and easily separated off the lateral chest wall.[19] If this space is only loosely connected to the chest wall, then the gas could dissect between the chest wall and the parietal pleura and create a pseudopneumothorax. This pseudopneumothorax would clinically act similar to a pneumothorax and would be treated in a similar fashion.

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ROBERT J. DOCKHORN, M.D., a
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Antigen Deterioration Rate of Aqueous Ragweed Pollen Extract

A Study

The perpetuation of the time-honored technique of direct skin testing is being challenged today because of the emergence of immunologic techniques that could replace it, such as basophil histamine release and radioallergosorbent tests. These tests eliminate the risk of untoward reactions during skin testing. The correlation of basophil histamine release and standard skin testing technique is greater than 90%.[1] The RAST, developed by Wide, Bennich and Johansson, shows promise of comparing favorably with the traditional skin testing and the more established histamine release. In the hands of these workers, the RAST agreed with skin testing in 70% of cases.[2] Both of these tests require skilled laboratory techniques and hours or days of laboratory work. Most of the dissatisfaction and criticism of skin testing stems from the use of extracts that are unstable and whose biologic potency is unknown.

A study was conducted to determine the deterioration rate of aqueous ragweed pollen extracts during a period of one year. For this purpose,
lyophilized ragweed pollen extracts were provi
by Center Laboratories. After appropriate d
tions to 1,000, 100 and 10 protein nitrogen un
these antigens were administered by intrader
technique to ragweed sensitive patients. The
started in December, 1972 and ended in Decem
1973. Six of 34 patients were selected at rand
for basophil histamine release studies using r
weed preparations dated December, 1972 and I
cember, 1973. Two dilutions were used: 10 and
protein nitrogen units/ml.

Most dissatisfaction from skin testing stems from use of extracts that are unstable and whose biologic potency is unknown. Results of this study demonstrate that there is a minimal change in the antigenic composition of ragweed extracts properly diluted and stored for one year. The conclusion is that a carefully performed intradermal skin testing is still the allergists' best diagnostic procedure. The authors are from Children's Mercy Hospital where Dr. Dockhorn is Chief of the Allergy-Immunology Section and Dr. Brunidor-Cador is a Fellow in Allergy and Clinical Immunology. This paper was originally presented at the Missouri Allergy Society Meeting on April 5, 1974 in Kansas City.

MATERIALS AND METHODS

The test patients were ragweed-sensitive w
previous 3+ or 4+ reactions to ragweed by
prick test. Patients prone to systemic reactions
on a regimen of medication were excluded fr
the study. None of the patients had an acute
ness at the time of skin testing. The patients w
skin tested within 48 hours after appropriate di-
tions of the lyophilized extract.

The diluted extracts were kept at 20 C. The fi
vial of lyophilized extract was reconstituted a
diluted in December, 1972 and labelled Prep
Eight days after Prep 1, another vial was dilut
and labeled Prep 2. Thirty days after Prep
Prep 3 was reconstituted and diluted. Sixty d
after Prep 1, a new dilution from another vial w
done, and this was Prep 4 and so on. The last di-
tion or the Fresh Prep was done in Decemb
1973. Each time a new dilution was done, it w
skin-tested on patients within 48 hours, so a
Prep 1.

Hamilton #710 microliter syringes and 30-gau
needles were used. Ten, 100 or 1,000 protein nit
gen units or 0.01 ml of ragweed were delivered
produce the intradermal wheals. The wheals w
placed at the flexor surface of the forearms a
on the latero-posterior surface of the upper ar
avoiding the area within two inches of the cubi

ld or the wrist fold. The distance between eals was 2½ inches to avoid confluence of the actions. Buffered saline was the negative control, d histamine 1:100,000 was the positive control. pseudopod reactions occurred with two succes- e dilutions, testings with stronger solutions were t done.

The skin reactions were read 15 minutes after e testing. The wheal and flare were outlined th a ballpoint pen, a strip of Scotch magic nsparent tape # 810 was applied to the skin sur- ce, the reaction was recorded and was placed on per for permanent record.

Thirty-four ragweed-sensitive patients partici- ted in the intradermal skin testing. From these tients, six were subject-patients for histamine re- se. The control patients for this study were pe- atric clinic patients referred for allergy evalua- n who had negative reaction to ragweed and her antigens by prick test.

The histamine release for the human leukocyte ocedure was adapted from the May micrometh- l with some modifications.[3]

Ten cubic centimeters of blood are drawn from e patient into a heparinized syringe. One cubic ntimeter of plasma gel is added and allowed to nd for 30 minutes to one hour, until there is a arp separation of the plasma leukocyte layer and e red blood cell layer. The upper plasma leuko- te layer is pushed into a plastic test tube and ntrifuged at 1,000 rpm for ten minutes. The pernatant fluid is discarded and the cells are ashed with Tris-A Buffer three times. Finally, the lls are resuspended in Tris-ACM Buffer contain- g calcium, magnesium and trisma at pH 7.6. hen a sufficient volume of Tris-ACM is added to e cells for the proposed experiment. Antigen anks for ragweed-1972 and -1973, consisting of n and 100 protein nitrogen units for each year, e set up. Cell blanks and reagent blanks are set in duplicates. Total histamine tubes containing 8 ml leukocyte suspension, Tris-ACM with calci- n and magnesium and ragweed antigens ten and 0 protein nitrogen units of the year 1972 and 73 are set up in duplicates and treated with tanol. Sodium hydroxide is added and they are aken immediately. Histamine is reextracted from ptane-butanol layer into 0.1 N HCL. The hydro- loric acid layer of each tube is suctioned and ansferred to another tube to be incubated in an e water bath, after which sodium chloride and -opthaldialdehyde are added to form a flurophore. Fluorescence were measured by the Turner fluorometer.

TABLE 1

COMPARISON OF WHEAL SIZES OBTAINED IN RAGWEED SENSITIVE PATIENTS USING 10 PNU AND 100 PNU OF ORIGINAL AND FRESH SOLUTIONS

	Wheal Sizes (mm)			
	ORIGINAL SOLUTIONS		FRESH SOLUTIONS	
Patient	10 PNU (mm)	100 PNU (mm)	10 PNU (mm)	100 PNU (mm)
#1	9	21	15	24
#2	25	35	28	32
#3	15	29	20	29
#4	8	15	8	17
#5	20	42	25	50
#6	10	28	10	35

Original Solution: Prepared in December, 1972.
Fresh Solution: Prepared in December, 1973.

TABLE 2

AVERAGE % HISTAMINE RELEASE IN RAGWEED SENSITIVE AND CONTROL PATIENTS. COMPARISON OF HISTAMINE RELEASE VALUES IN RAGWEED SENSITIVE PATIENTS USING 10 AND 100 PNU OF ORIGINAL AND FRESH SOLUTIONS

	Average % Histamine Release			
	ORIGINAL SOLUTION		FRESH SOLUTION	
Patient	10 PNU	100 PNU	10 PNU	100 PNU
#1	23.7	71.5	27	73.5
#2	40.5	81.7	43	83.2
#3	15.2	67	21	68
#4	22	53.5	25.5	59.5
#5	22.7	73	24.5	80.7
#6	21	59	22.5	61.5
#7	2.7	3	3	3
#8	3	3	3	3
#9	3	3	3	3
#10	2.5	2.5	2.5	2.5
#11	3	3	3	3
#12	3	3	3	3

Patients #7-#12 are control patients.
Original Solution: Prepared in December, 1972.
Fresh Solution: Prepared in December, 1973.

The results are shown in Tables 1 and 2.

At the conclusion of the study, Antigen-E determinations on all the ragweed preparations were done by gel diffusion technique.[4]

The results are shown in Table 3.

Discussion

Our findings, as shown by the biologic tests (intradermal skin testing and histamine release), dem-

TABLE 3

ANTIGEN-E DETERMINATIONS IN THE RECONSTITUTED 20,000 PNU RAGWEED EXTRACT PREPARATIONS

Method: Agar gel diffusion
Control: Antigen-E (1 mg/ml)

Preparations:	*Diffusion Ring Measurements (mm)*
1	4.7
2	4.5
3	4.7
4	4.4
5	4.7
6	4.5
7	4.5
8	5.0

onstrate that there is a minimal change in the antigenic composition of ragweed extracts properly diluted and stored over one year. The basophil histamine release showed a good correlation with wheal and flare response of patients and to the antigen concentration of the ragweed preparations used. Antigen-E determinations have verified the antigen content of the preparations used and, therefore, their biologic potency when used as antigen for skin testing and histamine release. The relation is clear, then, that known biologic potency of extracts make good correlation with intradermal skin testing and histamine release. However, from the standpoint of practicality, simplicity and immediate availability of results, a carefully performed intradermal skin testing with extracts whose biologic potency are known is still the allergists' best diagnostic procedure at hand.

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Pro-Banthīne®
brand of
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Indications: Pro-Banthīne is effective as adjunctive therapy in the treatment of peptic ulcer. Dosage must be adjusted to the individual.

Contraindications: Glaucoma, obstructive disease of the gastrointestinal tract, obstructive uropathy, intestinal atony, toxic megacolon, hiatal hernia associated with reflux esophagitis, or unstable cardiovascular adjustment in acute hemorrhage.

Warnings: Patients with severe cardiac disease should be given this medication with caution. Fever and possibly heat stroke may occur due to anhidrosis.

Overdosage may cause a curare-like action, with loss of voluntary muscle control. For such patients prompt and continuing artificial respiration should be applied until the drug effect has been exhausted. Diarrhea in an ileostomy patient may indicate obstruction, and this possibility should be considered before administering Pro-Banthīne.

Precautions: Since varying degrees of urinary hesitancy may be evidenced by elderly males with prostatic hypertrophy, such patients should be advised to micturate at the time of taking the medication.

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Adverse Reactions: Varying degrees of drying of salivary secretions may occur as well as mydriasis and blurred vision. In addition the following adverse reactions have been reported: nervousness, drowsiness, dizziness, insomnia, headache, loss of the sense of taste, nausea, vomiting, constipation, impotence and allergic dermatitis.

Dosage and Administration: The recommended daily dosage for adult oral therapy is one 15-mg. tablet with meals and two at bedtime. Subsequent adjustment to the patient's requirements and tolerance must be made.

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Contraindications: Sulfonamide hypersensitivity; pregnancy at term and during nursing period; infants less than two months of age.

Warnings: Safety during pregnancy has not been established. Sulfonamides should not be used for group A beta-hemolytic streptococcal infections and will not eradicate or prevent sequelae (rheumatic fever, glomerulonephritis) of such infections. Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been reported and early clinical signs (sore throat, fever, pallor, purpura or jaundice) may indicate serious blood disorders. Frequent CBC and urinalysis with microscopic examination are recommended during sulfonamide therapy. Insufficient data on children under six with chronic renal disease.

Precautions: Use cautiously in patients with impaired renal or hepatic function, severe allergy, bronchial asthma; in glucose-6-phosphate dehydrogenase-deficient individuals in whom dose-related hemolysis may occur. Maintain adequate fluid intake to prevent crystalluria and stone formation.

Adverse Reactions: *Blood dyscrasias* (agranulocytosis, aplastic anemia, thrombocytopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia); *allergic reactions* (erythema multiforme, skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis); *gastrointestinal reactions* (nausea, emesis, abdominal pains, hepatitis, diarrhea, anorexia, pancreatitis and stomatitis); *CNS reactions* (headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo and insomnia); *miscellaneous reactions* (drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L.E. phenomenon). Due to certain chemical similarities with some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia as well as thyroid malignancies in rats following long-term administration. Cross-sensitivity with these agents may exist.

Dosage: Systemic sulfonamides are contraindicated in infants under 2 months of age (except adjunctively with pyrimethamine in congenital toxoplasmosis).

Usual adult dosage: 2 Gm (4 tabs or teasp.) initially, then 1 Gm *b.i.d.* or *t.i.d.* depending on severity of infection.

Usual child's dosage: 0.5 Gm (1 tab or teasp.)/20 lbs of body weight initially, then 0.25 Gm/20 lbs *b.i.d.* Maximum dose should not exceed 75 mg/kg/24 hrs.

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Before prescribing, see complete prescribing information in SK&F literature or *PDR*. The following is a brief summary.

* WARNING
This fixed combination drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual patient. If the fixed combination represents the dosage so determined, its use may be more convenient in patient management. The treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

* **Indications:** *Edema:* That associated with congestive heart failure, cirrhosis of the liver, the nephrotic syndrome; steroid-induced and idiopathic edema; edema resistant to other diuretic therapy. *Mild to moderate hypertension:* Usefulness of the triamterene component is limited to its potassium-sparing effect.

Contraindications: Pre-existing elevated serum potassium. Hypersensitivity to either component. Continued use in progressive renal or hepatic dysfunction or developing hyperkalemia.

Warnings: Do not use dietary potassium supplements or potassium salts unless hypokalemia develops or dietary potassium intake is markedly impaired. Enteric-coated potassium salts may cause small bowel stenosis with or without ulceration. Hyperkalemia (>5.4 mEq/L) has been reported in 4% of patients under 60 years, in 12% of patients over 60 years, and in less than 8% of patients overall. Rarely, cases have been associated with cardiac irregularities. Accordingly, **check serum potassium during therapy, particularly in patients with suspected or confirmed renal insufficiency (e.g., elderly or diabetics). If hyperkalemia develops, substitute a thiazide alone. If spironolactone is used concomitantly with 'Dyazide', check serum potassium frequently**—both can cause potassium retention and sometimes hyperkalemia. Two deaths have been reported in patients on such combined therapy (in one, recommended dosage was exceeded; in the other, serum electrolytes were not properly monitored). Observe patients on 'Dyazide' regularly for possible blood dyscrasias, liver damage or other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving Dyrenium (triamterene, SK&F). Rarely, leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with the thiazides. Watch for signs of impending coma in acutely ill cirrhotics. Thiazides are reported to cross the placental barrier and appear in breast milk. This may result in fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly other adverse reactions that have occurred in the adult. When used during pregnancy or in women who might bear children, weigh potential benefits against possible hazards to fetus.

Precautions: Do periodic serum electrolyte and BUN determinations. Do periodic hematologic studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in postsympathectomy patients. The following may occur: hyperuricemi and gout, reversible nitrogen retention, decreasin alkali reserve with possible metabolic acidosis, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), digitalis intoxication (ir hypokalemia). Use cautiously in surgical patients Concomitant use with antihypertensive agents ma result in an additive hypotensive effect. 'Dyazide interferes with fluorescent measurement o quinidine.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis; rash urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting (may indicate electrolyte imbalance), diarrhea, constipation other gastrointestinal disturbances. Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and, rarely, allergic pneumonitis hav occurred with thiazides alone.

Supplied: Bottles of 100 capsules; in Single Unit Packages of 100 (intended for institutional use only).

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Rheumatoid arthritis can sometimes spread like wildfire, with joint after joint going up inflamed: "The usual onset is manifested by spotty joint involvement but an acute onset of symmetrical polyarthritis may be noted."*

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100 mg. phenylbutazone USP
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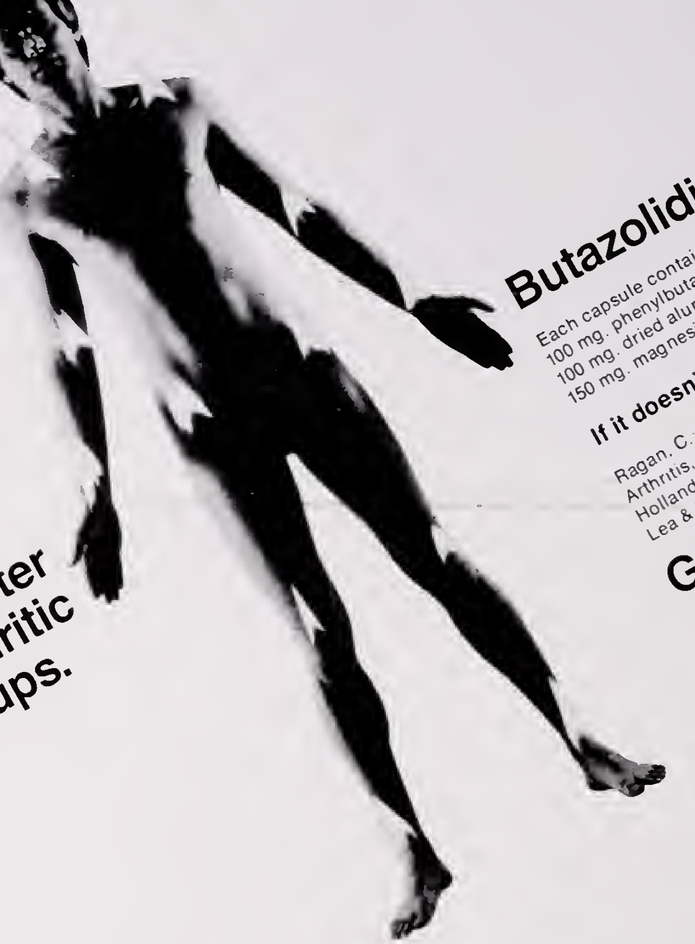
If it doesn't work in a week, forget it.



Butazolidin® alka

Each capsule contains:
100 mg. phenylbutazone USP
100 mg. dried aluminum hydroxide gel USP
150 mg. magnesium trisilicate USP

If it doesn't work in a week, forget it.

Ragan, C.: The Clinical Picture of Rheumatoid Arthritis, in Arthritis, ed. 8, edited by J. L. Hollander and D. J. McCarty, Jr., Philadelphia, Lea & Febiger, 1972, chap. 21, p. 335.

Geigy

Fire fighter for arthritic flare-ups.

Important Note: This drug is not a simple analgesic. Do not administer casually. Carefully evaluate patients before starting treatment and keep them under close supervision. Obtain a detailed history, and complete physical and laboratory examination (complete hemogram, urinalysis, etc.) before prescribing and at frequent intervals thereafter. Carefully select patients, avoiding those responsive to routine measures, contraindicated patients or those who cannot be observed frequently. Warn patients not to exceed recommended dosage. Short-term relief of severe symptoms with the smallest possible dosage is the goal of therapy. Dosage should be taken with meals or a full glass of milk. Substitute alka capsules for tablets if dyspeptic symptoms occur. Patients should discontinue the drug and report immediately any sign of: fever, sore throat, oral lesions (symptoms of blood dyscrasia); dyspepsia, epigastric pain, symptoms of anemia, black or tarry stools or other evidence of intestinal ulceration or hemorrhage, skin reactions, significant weight gain or edema. A one-week trial period is adequate. Discontinue in the absence of a favorable response. Restrict treatment periods to one week in patients over sixty.
Indications. Rheumatoid arthritis, osteoarthritis, bursitis, acute gouty arthritis and rheumatoid spondylitis.
Contraindications: Children 14 years or less; senile patients, history or symptoms of G.I. inflammation or ulceration including severe, recurrent or persistent dyspepsia; history or presence of drug allergy; blood dyscrasias, renal, hepatic or cardiac dysfunction, hypertension; thyroid disease; systemic edema; stomatitis and salivary gland enlargement due to the drug; polymyalgia rheumatica and temporal arteritis, patients receiving other potent chemotherapeutic agents, or long-term anticoagulant therapy.
Warnings: Age, weight, dosage, duration of therapy, existance of concomitant diseases, and concurrent potent chemotherapy affect incidence of toxic reactions. Carefully instruct and observe the individual patient, especially the aging (forty years and over) who have increased susceptibility to the toxicity of the drug. Use lowest effective dosage. Weigh initially unpredictable benefits against potential risk of severe, even fatal, reactions. The disease condition itself is unaltered by the drug. Use with caution in first trimester of pregnancy and in nursing mothers. Drug may appear in cord blood and breast milk. Serious, even fatal, blood dyscrasias, including aplastic anemia, may occur suddenly despite regular hemograms, and may become manifest days or weeks after cessation of drug. Any significant change in total white count, relative decrease in granulocytes, appearance of immature forms, or fall in hematocrit should signal immediate cessation of therapy and complete hematologic investigation. Unexplained bleeding involving CNS, adrenals, and G.I. tract has occurred. The drug may potentiate action of insulin, sulfonylurea, and sulfonamide-type agents. Carefully observe patients taking these agents. Nontoxic and toxic goiters and myxedema have been reported (the drug reduces iodine uptake by the thyroid). Blurred vision can be a significant toxic symptom worthy of a complete ophthalmological examination. Swelling of ankles or face in patients under sixty may be prevented by reducing dosage. If edema occurs in patients over sixty, discontinue drug.
Precautions: The following should be accomplished at regular intervals. Careful detailed history for disease being treated and detection of earliest signs of adverse reactions, complete physical examination including check of patient's weight; complete weekly (especially for the aging) or an every two week blood check, pertinent laboratory studies. Caution patients about participating in activity requiring alertness and coordination, as driving a car, etc. Cases of leukemia have been reported in patients with a history of short- and long-term therapy. The majority of these patients were over forty. Remember that arthritic-type pains can be the presenting symptom of leukemia.
Adverse Reactions: This is a potent drug; its misuse can lead to serious results. Review detailed information before beginning therapy. Ulcerative esophagitis, acute and reactivated gastric and duodenal ulcer with perforation and hemorrhage, ulceration and perforation of large bowel, occult G.I. bleeding with anemia, gastritis, epigastric pain, hematemesis, dyspepsia, nausea, vomiting and diarrhea, abdominal distention, agranulocytosis, aplastic anemia, hemolytic anemia, anemia due to blood loss including occult G.I. bleeding, thrombocytopenia, pancytopenia, leukemia, leukopenia, bone marrow depression, sodium and chloride retention, water retention and edema, plasma dilution, respiratory alkalosis, metabolic acidosis, fatal and nonfatal hepatitis (cholestasis may or may not be prominent), petechiae, purpura without thrombocytopenia, toxic pruritus, erythema nodosum, erythema multiforme, Stevens-Johnson syndrome, Lyell's syndrome (toxic necrotizing epidermolysis), exfoliative dermatitis, serum sickness, hypersensitivity angiitis (polyarteritis), anaphylactic shock, urticaria, arthralgia, fever, rashes (all allergic reactions require prompt and permanent withdrawal of the drug), proteinuria, hematuria, oliguria, anuria, renal failure with azotemia, glomerulonephritis, acute tubular necrosis, nephrotic syndrome, bilateral renal cortical necrosis, renal stones, ureteral obstruction with uric acid crystals due to uricosuric action of drug, impaired renal function, cardiac decompensation, hypertension, pericarditis, diffuse interstitial myocarditis with muscle necrosis, perivascular granulomata, aggravation of temporal arteritis in patients with polymyalgia rheumatica, optic neuritis, blurred vision, retinal hemorrhage, toxic amblyopia, retinal detachment, hearing loss, hyperglycemia, thyroid hyperplasia, toxic goiter, association of hyperthyroidism and hypothyroidism (causal relationship not established), agitation, confusional states, lethargy; CNS reactions associated with overdosage, including convulsions, euphoria, psychosis, depression, headaches, hallucinations, giddiness, vertigo, coma, hyperventilation, insomnia, ulcerative stomatitis, salivary gland enlargement.
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President's Message

An interesting paradox surfaced recently as the physi-
ns in Louisiana worked for passage of wide-ranging
islation to improve the malpractice insurance situa-
n in their state—there was *too much* physician ac-
ity.

Note I did not say too much physician interest or
ysician support, but rather, *activity!*

The Louisiana State Medical Society House of Dele-
tes had developed a Malpractice Package designed
und the AMA's model malpractice legislation. This is
ackage of eight bills including ones dealing with such
as of the law as informed consent, burden of proof,
tute of limitation, joint underwriting agreement and
itration panels.

Meanwhile, the Council on Medical Staffs, with its
tional headquarters in Louisiana, already had several
ces of malpractice legislation introduced into the Loui-
na Legislature. One bill was to limit liability to
00,000. The Louisiana Medical Society House en-
raged support of this bill.

Just before the House met, Indiana had passed its
nous "Indiana Bill." Following House debate and le-
counsel's opinion that the Louisiana Legislature
uld not pass an "Indiana style" package, the Society
cided on its own approach.

However, after the introduction of the Society's pack-
e, an energetic private physician, not fully aware
the Society's position, asked his local Representative
introduce an "Indiana style bill." The Society's Coun-
on Legislation, given authority to implement the
ciety package, tried to persuade the physician to
thdraw the bill with the reasoning that the physi-
ns of Louisiana must show a united front before
Legislature. The Society feared that with one physi-
n-group going one way and other groups going other
ys, the effectiveness of medicine before the Legisla-
e would be diluted and possibly risk the chance for
ssage of any helpful legislation. The energetic physi-
n, who had now gathered a small but dedicated fol-
ving, refused to withdraw his bill.

The following weeks were filled with confusion and
efforts of the Society in the Legislature were nil,
cording to Leon M. Langley, Jr. of the Society Staff.
lany physicians who jammed the Legislative com-
ttee rooms during the initial hearings on the package
re discouraged and disillusioned by what occurred.
e Council on Medical Staffs would take a position on
ill and the Society would take another position. The
islators wondered if the physicians of Louisiana knew
at it was they wanted in the way of reform legisla-
n," said Langley.

The Louisiana Medical Society President quickly
lled a meeting of the Council on Legislation and in-
ed proponents of the "Indiana Bill" and the President
the Council on Medical Staffs. The outcome of this
d other meetings was that certain parts of the "Indi-
a Bill" were included as part of the Society package

R. Allen Chandler, M.D.

and the President of the Council on Medical Staffs was given the authority to represent the Society on some of the pending legislation. The next legislative committee hearing, said Langley, showed the polished presentation by the Society that finally persuaded the legislators to favorably report the bills out of committee.

The Louisiana Legislature, with the concerted efforts of hundreds of physicians making *one-to-one contacts* with their Legislators making the difference, went on to pass nearly all of the Society's malpractice package.

Langley closed by adding: "The battle was not easily won, but with the cooperation of the Louisiana Medical Society membership, it was one to be extremely proud of winning. Louisiana physicians have demonstrated how a profession can come together and work toward a goal which is not only of benefit to the profession but to their patients as well. The story of success in Louisiana is one that can be accomplished in any state with the same amount of determination, work and *total* cooperation of its membership."

I have related the "Louisiana Story" to you because we Missouri physicians may be facing a similar situation in the near future as our General Assembly prepares to convene in January, 1976.

Your Association will need the assistance of a great many of our members . . . remember, personal contact with your own Legislator is the best type of "lobbying" in the world. You will be hearing more on this as the Legislative Session approaches.

I feel it is very important that we learn from Louisiana's experience and keep all of our physicians working under the umbrella of the Missouri State Medical Association. We cannot afford to splinter off into separate groups and dilute our strength. The best hope for passage of beneficial malpractice insurance legislation is through the coordinated efforts of all the physicians in Missouri.

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Woman's Auxiliary

Mrs. William R. McPhee
President

It is my pleasure to present another guest columnist, Jean Gordon, who is chairman of the Auxiliary's Missouri State Medical Foundation committee. Jean brings an exciting invitation for every MSMA and Auxiliary member who enjoys a special talent or creative hobby.

Warmly,

Mary Kay McPhee

Dear Doctor:

If possession of a talent is a "gift," then sharing that talent for the benefit of others is "giving the gift of gifts!"

This is the key to the upcoming SILENT AUCTION of original art and craft items, a project designed to give talented and artistic members of the MSMA and Auxiliary a chance to "shine" plus a special opportunity to share your talents in the interest of education and making loan funds available for Missouri medical students who need financial support.

The SILENT AUCTION is one of the most attractive and exciting projects ever to be undertaken by the MSMA Auxiliary. It will be held during the 1976 Annual Session on April 1-4 at the Crown Center Hotel in Kansas City. All items to be sold will be art and craft creations donated by MSMA members and their wives. The artwork may be in any medium, such as painting, sculpture, photography, wood carving, china painting, leather work, embroidery, quilting and weaving.

All proceeds will be donated to the Missouri State Medical Foundation.

Please consider this as our invitation to you, personally, to participate. The success of the SILENT AUCTION will depend upon the donations and cooperation of our members. Please contact the President of your county auxiliary or me today and tell us what your artistic contribution will be.

Again, we invite our talented MSMA members to share their talents at the silent auction so that more deserving men and women can complete their medical educations.

Sincerely,
Jean Gordon
(Mrs. James A. Gordon)
600 Boonville Road
Jefferson City 65101
(314-636-3074)

LETTERS to the Editor

To the Editor:

It is very encouraging to the members of the medical profession to know that the members of our legislature are beginning to look for solutions to the extremely serious matter of malpractice insurance. Until now, the full repercussions of this problem have not been fully appreciated by members of our legislative branches.

Although it is encouraging, I do feel that the recommendation introduced by Sen. Albert Spradling and the other senators is not the solution to the problem.

In simple words, the problem of malpractice insurance in America lies in the fact that there is no legislation available to accomplish the following:

1. Establish the responsibility of physicians and everyone involved in the care of patients.
2. Limit the amount of compensation in cases of malpractice.

In this day and age, patients expect too much of a doctor and do not seem to realize that we are physicians and not magicians. The practice of medicine should be viewed with a different philosophical approach and with the basic concept that no doctor in his right mind would intentionally do anything to hurt a patient. Life in itself is a risk, and many patients face risks in tre
ment for which a physician should not be liable.

In the practice of medicine, there are certain ca
in which a patient is injured even when the physic
does his very best. In such cases, reasonable compen
tion should be awarded, but certain limits should
established, including the attorney's fee. If the comp
sation awarded to a patient to help his or her recov
goes into the attorney's pocket, the basic concept
compensation is defeated.

We should fight to gain respect for the operati
permit, which is a legal document. If the complicatic
of which the patient complains have been specifica
spelled out in the operative permit, the doctor shou
not be held responsible for any damages that mi
occur.

For the benefit of the patient's needs, let's hope th
the legislature finds a fair solution to this proble
which is threatening the practice of medicine
seriously.

Sincerely,
Bolivar M. Escobedo, M.
St. Louis

★

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New Members

Arun R. Baja, M.D., 217 Oak, Poplar Bluff, has come a member of Butler-Wayne-Ripley-Carter unty Medical Society. Dr. Baja is a native of dia, received his preliminary education at Nag- r University and his M.D. degree at Nagpur iversity in 1967. He specializes in general prac- e and general surgery.

Leslie L. Barton, M.D., 3535 S. Jefferson, St. uis, has become a member of St. Louis County edical Society. Dr. Barton is a native of New rk, N. Y., received her preliminary education at nter College and her M.D. degree at the Uni- rsity of Chicago in 1966. She specializes in pedi- ics.

Robert L. Bonsanti, M.D., 3394 McKelvey, idgeton, has become a member of St. Louis unty Medical Society. Dr. Bonsanti is a native Teaneck, N. J., received his preliminary educa- n at the University of Portland and his M.D. gree at St. Louis University in 1964. He spe- lizes in internal medicine.

D. J. Chanduwadia, M.D., 500 Northwest Plaza, Ann, has become a member of St. Louis County edical Society. Dr. Chanduwadia is a native of mbay, India, received his preliminary education The Jai Hind and his M.D. degree at The Grant edical College in 1968. He specializes in ob- trics and gynecology.

Michael J. Chehval, M.D., 1035 Bellevue, St. uis, has become a member of St. Louis Medical ciety. Dr. Chehval is a native of Wisconsin, re- ived his preliminary education at Northeast Mis- uri State University and his M.D. degree at St. uis University in 1967. He specializes in urology.

Edward J. Collins, M.D., 1325 S. Grand Blvd., . Louis, has become a member of St. Louis edical Society. Dr. Collins is a native of Illinois, ceived his preliminary education at Loras College d his M.D. degree at the University of Illinois in 71. He specializes in ophthalmology.

Lawrence G. Evans, M.D., 1325 S. Grand Blvd., . Louis, has become a member of St. Louis edical Society. Dr. Evans is a native of St. Louis, ceived his preliminary education at St. Louis niversity and his M.D. degree at St. Louis Uni- rsity in 1968. He specializes in orthopedics.

Rocco J. Fiordelisi, M.D., 5859 Walsh, St. Louis, has become a member of St. Louis Medical Society. Dr. Fiordelisi is a native of Illinois, received his preliminary education at Northern Illinois University and his M.D. degree at St. Louis University in 1970. He specializes in general surgery.

C. Stephen Foster, M.D., Barnes Hospital Plaza, St. Louis, has become a member of St. Louis Medical Society. Dr. Foster is a native of West Virginia, received his preliminary education at Duke University and his M.D. degree at Duke University in 1969. He specializes in ophthalmology.

Andrew F. Galakatos, M.D., 777 S. New Ballas Rd., St. Louis, has become a member of St. Louis Medical Society. Dr. Galakatos is a native of St. Louis, received his preliminary education at St. Louis College of Pharmacy and his M.D. degree at the University of Missouri in 1965. He specializes in obstetrics and gynecology and oncology.

Paul J. Gill, M.D., 1211 S. Glenstone, Springfield, has become a member of Greene County Medical Society. Dr. Gill is a native of Sterling, Kan., received his preliminary education at the University of Kansas and his M.D. degree at the University of Kansas in 1969. He specializes in internal medicine and hematology.

Harry N. Grannemann, M.D., 1000 W. 10th, Rolla, has become a member of Mid-Mo County Medical Society. Dr. Grannemann is a native of St. Louis, received his preliminary education at the University of Rolla and his M.D. degree at the University of Missouri in 1965. He specializes in pathology.

Doris Hawkins, M.D., 6301 Rockhill Rd., Kansas City, has become a member of Jackson County Medical Society. Dr. Hawkins is a native of Kansas City, received her preliminary education at the University of Redlands and her M.D. degree at the University of Missouri in 1967. She specializes in anesthesiology.

Barry A. Hiatt, M.D., 216 S. Kingshighway, St. Louis, has become a member of St. Louis Medical Society. Dr. Hiatt is a native of Washington, received his preliminary education at the University of Washington and his M.D. degree at the University of California in 1966. He specializes in psychiatry.

Kim Won Hwang, M.D., 1325 S. Grand Blvd., St. Louis, has become a member of St. Louis Med-

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ical Society. Dr. Hwang is a native of Korea, ceived his preliminary education at the Colleg Kyungbook and his M.D. degree at the Med School of Kyunbook in 1967. He specializes anesthesiology.

Tjaz A. Jatala, M.D., 8510 Skyline, St. Louis, become a member of St. Louis County Med Society. Dr. Jatala is a native of Sialkot, Pakis received his preliminary education at Murray lege and his M.D. degree at Nishtar Medical lege in 1959. He specializes in psychiatry.

Sripatt Kulkamthorn, M.D., 1755 S. Grand, Louis, has become a member of St. Louis Med Society. Dr. Kulkamthorn is a native of Thaila received his preliminary education at Bang Christian College and his M.D. degree at Chu longkorn University in 1968. He specializes general surgery.

Gon Ten Kuo, M.D., 2601 N. Whittier, St. Lo has become a member of St. Louis Medical Soci Dr. Kuo is a native of Taiwan, received his p liminary education at National Chung Kung U versity and his M.D. degree at Chung Shan M ical College in 1968. He specializes in obstetr and gynecology.

William P. Lampros, M.D., 1035 Bellevue, Louis, has become a member of St. Louis Medi Society. Dr. Lampros is a native of Greece, ceived his preliminary education at St. Louis U versity and his M.D. degree at St. Louis Univers in 1967. He specializes in otolaryngology.

Chi-Hsi Lin, M.D., 2030 S. National, Springfie has become a member of Greene County Medic Society. Dr. Lin is a native of Taiwan, receiv his preliminary education at Kaohsiung Medic College and his M.D. degree at Kaohsiung Medic College in 1959. He specializes in neurology.

Hugh Lundman, M.D., 609 Cherry, Springfiel has become a member of Greene County Medic Society. Dr. Lundman is a native of Joplin, ceived his preliminary education at Kansas Sta College and his M.D. degree at the University Missouri in 1967. He specializes in general surger

William A. McCrea, M.D., 1211 Glenston Springfield, has become a member of Gree County Medical Society. Dr. McCrea is a nati of Pittsburgh, Pa., received his preliminary educa tion at Mount Union College and his M.D. degr at the University of Pittsburgh in 1945. He is general practice.

Kamal Nagi, M.D., 5400 Arsenal, St. Louis, has ome a member of St. Louis Medical Society. . Nagi is a native of Egypt, received his preinary education at Cairo University and his D. degree at Cairo University in 1957. He spelizes in psychiatry.

David E. Nelson, M.D., 1443 N. Robberson, ingfield, has become a member of Greene Coun-Medical Society. Dr. Nelson is a native of Mantan, Kan., received his preliminary education at nsas State University and his M.D. degree at the iversity of Kansas in 1968. He specializes in gnostic radiology.

Thomas A. Orszulak, M.D., 1325 S. Grand Blvd., Louis, has become a member of St. Louis Medl Society. Dr. Orszulak is a native of Pennsylnia, received his preliminary education at St. ncent College and his M.D. degree at St. Louis iversity in 1971. He specializes in general sury.

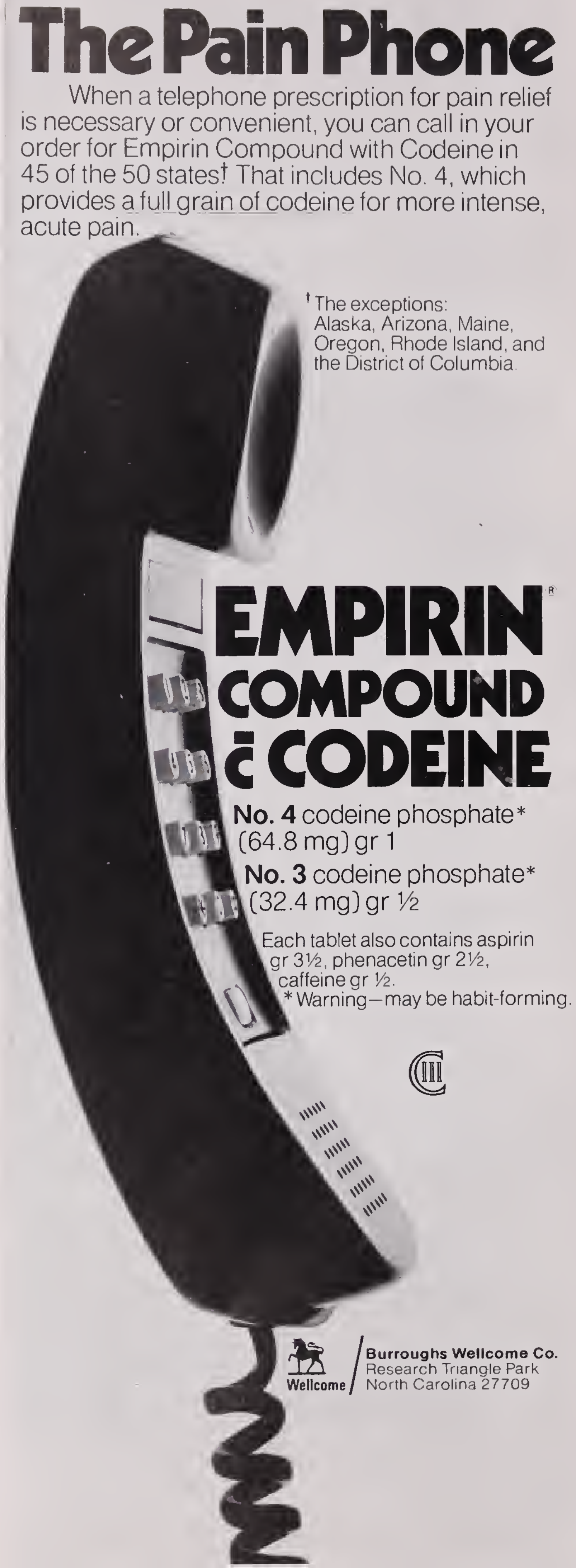
D. G. Parulekar, M.D., 6126 Kingsfont, Florist, has become a member of St. Louis Medical ciety. Dr. Parulekar is a native of India, received preliminary education at Wilson College and M.D. degree at Seth G. S. Medical College in 69. He specializes in general surgery.

David Pfefferkorn, M.D., 1325 S. Grand Blvd., Louis, has become a member of St. Louis dical Society. Dr. Pfefferkorn is a native of ssouri, received his preliminary education at the iversity of Missouri and his M.D. degree at St. uis University in 1973. He specializes in internal dicine.

Chintana Phipatanakul, M.D., 1125 Graham Rd., rissant, has become a member of St. Louis unty Medical Society. Dr. Phipatanakul is a ive of Bangkok, Thailand, received her preinary education at Chulalongkorn University d her M.D. degree at Chulalongkorn Hospital dical School in 1965. She specializes in allergy d immunology.

Gorge PuthenPurackal, M.D., 6420 Clayton Rd., Louis, has become a member of St. Louis Medl Society. Dr. PuthenPurackal is a native of lia, received his preliminary education at Kerala iversity and his M.D. degree at Kasturba Medl College in 1965. He specializes in internal dicine.

Arteso C. Raborar, M.D., 207 Professional Bldg., ringfield, has become a member of Greene Coun-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ty Medical Society. Dr. Raborar is a native of Albany, Philippines, received his preliminary education at the University of Santo Tomas and his M.D. degree at the University of Santo Tomas in 1965. He specializes in pathology.

Gary A. Ratkin, M.D., 100 N. Euclid, St. Louis, has become a member of St. Louis Medical Society. Dr. Ratkin is a native of New York, received his preliminary education at Rice University and his M.D. degree at Washington University in 1967. He specializes in internal medicine, hematology and oncology.

Carol S. Saunders, M.D., 807 Stadium, Columbia, has become a member of Boone County Medical Society. Dr. Saunders is a native of Newton, Ia., received his preliminary education at the University of Iowa and his M.D. degree at the University of Iowa in 1960. He specializes in pediatrics.

Sioe S. Tan, M.D., Farmington State Hospital, Farmington, has become a member of Mineral Area County Medical Society. Dr. Tan is a native of Indonesia, received his preliminary education at the University of Indonesia and his M.D. degree at the University of Indonesia in 1959. He is in general practice.

Leroy W. Vaughn, M.D., 4658 San Diego Co
St. Louis, has become a member of St. Louis M
cal Society. Dr. Vaughn is a native of Califor
received his preliminary education at Moreh
College and his M.D. degree at Wayne State
versity in 1973. He specializes in ophthalmology.

Robert L. Venegoni, M.D., 6700 Troost, Ka
City, has become a member of Jackson Co
Medical Society. Dr. Venegoni is a native of
Louis, received his preliminary education at
Louis University and his M.D. degree at the
versity of Missouri in 1971. He specializes in a
thesiology.

Garey L. Watkins, M.D., 2601 N. Whittier,
Louis, has become a member of St. Louis Med
Society. Dr. Watkins is a native of Illinois,
ceived his preliminary education at Southern
nois University in 1971. He specializes in ophth
mology.

K. P. Zacharias, M.D., 2639 Miami, St. Lo
has become a member of St. Louis Medical Soci
Dr. Zacharias is a native of India, received his
liminary education at S. B. College and his M
degree at Trivandrum College in 1965. He spec
izes in surgery.

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(Continued from page 544)

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LEO H. POLLOCK, M.D.

Missouri Medicine in Review

FRTY YEARS AGO

One of the most interesting phases of the AMA Aantic City session to Missouri members was the section of Kansas City as the meeting place for 136. Kansas City and the Jackson County Medical Siety had planned diligently for this meeting. It wl be the first session of the American Medical Aociation to be held in Kansas City. Several sesns have been held in St. Louis, notably in 1854, 1'3, 1886, 1910 and 1922.

Dr. Ross A. Woolsey, St. Louis, was chosen as Psident-Elect of the Missouri State Medical Assiation by the House of Delegates at the annual ssion in Excelsior Springs on May 6-10, 1935. Dr. Woolsey will serve as President-Elect in 1935-1936 ad as President in 1936-1937.

A reunion of the class of 1895 of the Missouri Mdical College in St. Louis was held on June 15-16 a Wildwood Springs Hotel in Steelville. The exeises lasted 24 hours. With the exception of a few hrs of sleep, each member was busy every minu. Dr. R. J. Terry acted as toastmaster. Dr. R. E. Slueter gave a history of the class. Dr. John Zhorsky read a poem, "40 Years Ago," and Dr. N George Gorin related some interesting reminiscnces. All are of St. Louis.

TWENTY-FIVE YEARS AGO

C. Edgar Virden, M.D., Kansas City, was elected Psident-Elect of the Missouri State Medical Assiation at the 92nd Annual Session held in St. Luis on March 26-29, 1950. Dr. Virden obtained h medical training at Northwestern University ad received his degree from that school in 1920. H interned at St. Joseph Hospital in Kansas City. H was President of Jackson County Medical Socty in 1945.

John F. Bowser, M.D., Kansas City, spoke before the Optimist Club of Independence on May 10 on "Radiologic Experiences in the ETO."—W. A. Bloom, M.D., Fayette, spoke before the Rotary Club of Fayette on May 17 and discussed "National Health Insurance."

James Barrett Brown, M.D., St. Louis, has been elected president of the Washington University Medical Alumni Association. Other officers are Drs. A. N. Arneson, St. Louis, first vice-president; Wendell G. Scott, St. Louis, second vice-president; and George W. Ittner, St. Louis, secretary-treasurer.

Dr. John S. Knight, Kansas City, was installed as president of the Kansas City O.O.R.L. Society on May 17. Dr. A. W. McAlester III was elected president-elect; Winfred L. Post, Joplin, vice-president; and B. C. Trowbridge, M.D., Kansas City, secretary.

TEN YEARS AGO

The American Medical Association has advised its member-physicians that they will risk prosecution under the Sherman Antitrust Act if they act in concert to boycott the government's new "medicare program" (Public Law 89-97). The warning, however, applies only to organized or joint action.

After studying all legal aspects of the situation, AMA counsel said that individual physicians, acting independently and not in concert, may lawfully refuse to accept a patient who is receiving benefits under the medical care of the aged program. The AMA Board of Trustees pointed out that individual physicians who decline to "participate" in the program may face certain other problems.

In a formal statement, the Board stated, "The physician's right to practice in a hospital is not vested. He is obligated to abide by the reasonable rules and regulations imposed by the hospital administration. Such rules and regulations may directly or indirectly require the cooperation of the physician in assisting the hospital to participate as a provider of services under the law. Representatives of the AMA have met with President Lyndon B. Johnson and top administrative officials and have been assured that no 'medicare' regulations will be put into effect until AMA has had a full opportunity to evaluate the proposals and to recommend changes."

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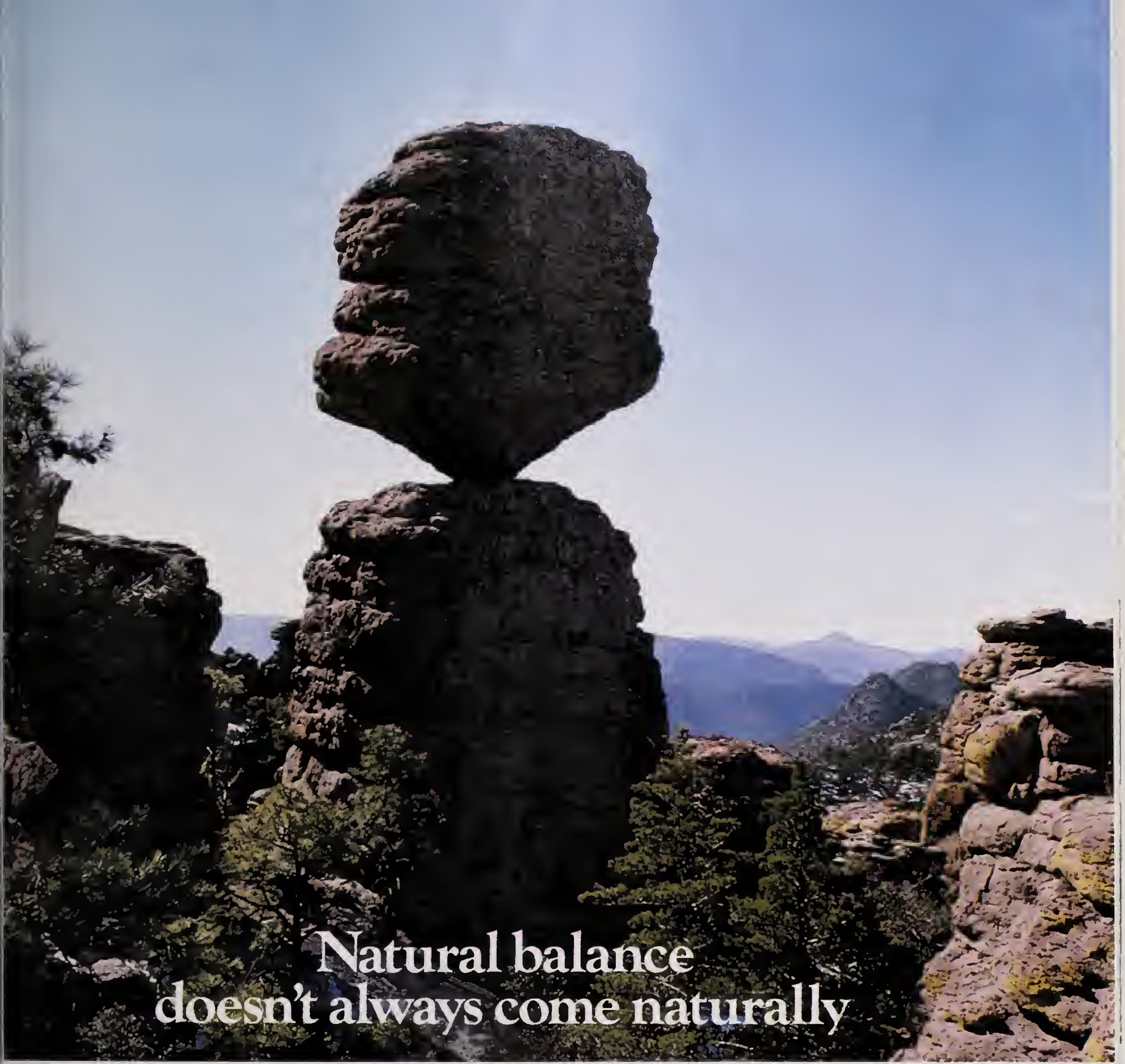

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sibly Effective: Management of vertigo associated with diseases affecting the ular system.

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CONTRAINDICATIONS. Administration of Antivert (meclizine HCl) during pregnancy or to women who may become pregnant is contraindicated in view of the teratogenic effect of the drug in rats.

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WARNINGS. Since drowsiness may, on occasion, occur with use of this drug, patients should be warned of this possibility and cautioned against driving a car or operating dangerous machinery.

Usage in Children: Clinical studies establishing safety and effectiveness in children have not been done; therefore, usage is not recommended in the pediatric age group.

Usage in Pregnancy: See "Contraindications."

ADVERSE REACTIONS. Drowsiness, dry mouth and, on rare occasions, blurred vision have been reported.

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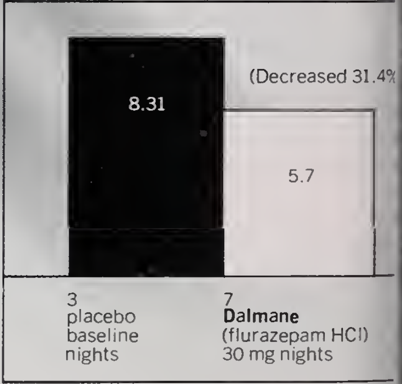

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Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. Caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Use in women who are or may become pregnant only when potential benefits have been weighed against possible hazards. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated, initial dosage should be limited to 15 mg to preclude oversedation, dizziness and/or ataxia. If combined with other drugs having hypnotic or CNS-depressant effects, consider potential additive effects. Employ usual precautions in patients who are severely depressed, or with latent depression or suicidal tendencies. Periodic blood counts and liver and kidney function tests are advised during repeated therapy. Observe usual precautions in presence of impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported were headache, heartburn, upset stomach, nausea vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins and alkaline phosphatase. Paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity, have also been reported in rare instances.

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Food and Drug
Administration

The idea of a so-called pati
package insert has been around
a long time. Many physicians alr
use written instruction sheets tc
provide patients with informatio
about the drugs they are taking.
some physicians give verbal inst
tions; but in too many instances
these are what I call eye-glazing
ercises. I have seen patients sit
glazed eyes listening to a rapid-f
lecture by a hurried physician w
has 20 people out in his waiting
room. These patients aren't give
sufficient understanding and th
fore do not follow instructions. S
think the idea of an official pack
insert for patients is a good one.
Perhaps we should really think c
this kind of information simply a
extension of drug labeling.

The benefits of patient involveme

Many physicians may not r
ize how frequently a patient obta
his drug information from Aunt
Tillie or the next door neighbor.
this information is almost alwa
bad or irrelevant to the case at h
Furthermore, the incentive to gc
along with a prescribed progran
slim if the only reading matter tl
patient receives, along with his
scription, is a bill.

As an educator I am impres
by the principle that the best wa
get someone to do something is
involve him in the process. So th

Dr. James H. Sammons
Executive Vice President
of the American
Medical Association

I think there are advantage
well as some real disadvantages
a patient package insert. When y
begin to use semi-medical or me
cal terms to describe complicati
or possible sequelae of disease o
treatment, you may frighten the
tient—particularly since the mor
highly sophisticated patient is nc
the one who is going to read the i
sert. The patient who will read it
the one most susceptible to frigh
and confusion by the language.

On the positive side, a pack
insert will probably give the patie
better insight into why he is bein
treated the way he is, and it may
give the physician a little bit mor
time. But it does not remove fron
the physician the need or obligat
to explain the insert.

Some pitfalls in the inclusion of side effects

Certainly a patient should b
warned of the possibility of serio
side reactions—to know what the
real dangers are. But it doesn't d
bit of good to indicate that a patie
on oral penicillin may develop a
rash, itching, or a drop in blood
pressure. Or that he may faint. I
think the real danger is that frigh
engendered by the insert may po
sibly outweigh the potential good

urpose of drug information patient is to get his coopera- following a drug regimen.

ation and distribution of e drug information

/e would hope to amass infor- n from physicians, medical es, the pharmaceutical indus- l centers of medical learning. imate responsibility for uni- beling must, however, rest e Food and Drug Administra- here is nothing wrong with ency saying, "this informa- generally agreed upon and re it should be used," as long process for getting the infor- n is sound.

istribution of the information blem. In great measure it depend on the medication in n. For example, in the case njectable long-acting proges- , we would think it mandatory e two separate leaflets—a ne for the patient to read be- tting the first shot and a long take home in order to make a n about continuing therapy. case, the information might directly on the package and movable at all. But for a medi- like an antihistamine this ation might be issued sepa- thus giving the physician the of distribution. This could ve the placebo use, etc.

It is in the distribution of patient information that the pharmacist may get involved. As professionals and members of the health-care team and as a most important source of drug information to patients, pharmacists should be responsible for keeping medical and drug records on patients. It is also logical that they should distribute drug information to them.

Realistic problems must be considered

We have to expect that the introduction of an information device will also create new problems. First, how can we communicate complex and sophisticated information to people of widely divergent socioeconomic and ethnic groups? Second, what will we say? And third, how can we counteract the negative attitude of many physicians toward any outside influence or input? Hopefully the medical profession will respond by anticipating the problems and helping to solve them. Assuming we can also solve the difficulty of communicating information to diverse groups throughout the United States, our remaining task will be the inclusion of appropriate material.

What information is appropriate?

In my opinion, technical, chemical and such types of material should not be included. And there is no point in the routine listing of side effects like nausea and vomiting which seem to apply to practically all drugs, unless it is common with the drug. However, serious side effects should be listed, as should information about a medication that is potentially risky for other reasons.

Other pertinent information might consist of drug interactions, the need for laboratory follow-up, and special storage requirements. What we want to include is information that will help increase patient compliance with the therapy.

Positive aspects of patient drug information

Labeling medication for the patient would accomplish a number of good things: the patient could be on the lookout for possible serious side effects; his compliance would increase through greater understanding; the physician would be a better source of information since he would be freer to use his time more effectively; other members of the health-care team would benefit through patient understanding and cooperation; and, finally, the physician-patient relationship would probably be enhanced by the greater understanding on the part of the patient of what the physician is doing for him.

---

e doctor can remove that fear r 30 minutes of conversation. m not suggesting that we ld any information from the t because, first of all, it would lly dishonest and secondly, it defeat the very purpose of the . I do think that a patient on the ontrol pill should know about cidence of phlebothrombosis. f you're going to tell a patient cidence of serious adverse re- s, then you have to tell him concerned medical decision ade to use a particular medi- in his situation after careful deration of the incidence of ications or side effects.

onally unstable patients pose ial problem

here are patients who, be- of severe emotional problems, not handle the information ned in a patient package in- et if we are going to have a ge insert at all, we just can't wo inserts. I think we might have to tell the families of patients to remove the insert he package.

implications of the patient ge insert

Just what effect would a patient package insert have on malpractice? We could try to avoid any legal implications by pointing out that the physician has selected a particular medication because, in his professional judgment, it is the treatment of choice. For instance, you can't tell everyone taking antihistamines not to work just because a few patients develop extreme drowsiness which can lead to accidents. And what about the very small incidence of aplastic anemia rarely associated with chloramphenicol? If, based on sensitivity studies and other criteria, we decide to employ this particular antibiotic, we do so in full knowledge of this serious potential side effect. It's not a simple problem.

How do we handle an insert for medication used for a placebo effect?

With rare exceptions, physicians no longer use medications for a placebo effect. This question does raise the issue of how a patient may react to receiving a medication without a package insert.

Preparation of the package insert

The development of the insert ought to be a joint operation between physicians, the pharmaceutical industry, the A.M.A. and the F.D.A.

I view the A.M.A.'s role as a coordinator or catalyst. It is the only organization through which the profession as a whole, irrespective of specialty, can speak. It has relatively instant access to all the medical expertise in this country. And it can bring that professional expertise together to ensure a better package insert. The A.M.A. can work in conjunction with the industry that has produced the product and which is ultimately going to supply the insert.

I don't think we should rely, or expect to rely, on legislative committees and their nonprofessional staffs to make these decisions when it is perfectly within the power of the two groups to resolve the issues in the very best American tradition—without the government forcing us to do it. I think the F.D.A. has to be involved, but I'd like them to become involved because they were asked to become involved.

Pharmaceutical
Manufacturers Association
1155 Fifteenth Street, N.W.
Washington, D.C. 20005

P·M·A

In Memoriam

Henry A. Schroeder, M.D., P.O. Box 4376, St. Thomas, V.I., a graduate of Columbia College, 1933; member St. Louis Medical Society; age 68; died April 20, 1975.

Walter R. King, M.D., 7721 State Line, Kansas City, a graduate of Creighton University, 1951; member Jackson County Medical Society; age 56; died June 6, 1975.

Horace H. Shackelford, M.D., 4475 W. Pine Blvd., St. Louis, a graduate of Washington University, 1918; member St. Louis Medical Society; age 85; died June 12, 1975.

Francis L. Kozal, M.D., Crystal City, a graduate of Washington University, 1949; member Jefferson County Medical Society; age 52; died June 13, 1975.

John A. Rogers, M.D., 8124 Roxburgh, Clayton, a graduate of Tulane University, 1930; member St. Louis County Medical Society; age 75; died June 14, 1975.

Forrest L. Martin, M.D., 912 Briarwood, Nevada, a graduate of Washington University, 1925; member West Central County Medical Society; age 75; died June 18, 1975.

Eugene B. Robichaux, M.D., 810 Bell Dr., Excelsior Springs, a graduate of Tulane University, 1932; member Clay County Medical Society; age 65; died June 18, 1975.

Rush Turner, M.D., 2 North Euclid Ave., St. Louis, a graduate of St. Louis College, 1914; member St. Louis Medical Society; age 91; died June 18, 1975.

Richard C. Lanning, M.D., Ste. Genevieve, a graduate of St. Louis University, 1926; member Perry-Ste. Genevieve County Medical Society; age 74; died June 19, 1975.

John H. Ogilvie, M.D., Box 157, Rt. 1, Gravois Mills, a graduate of Harvard University, 1921; member Jackson County Medical Society; age 80; died June 24, 1975.

John M. Powers, M.D., 3838 Blue Ridge Blvd., Independence, a graduate of the University of Kansas, 1931; member Jackson County Medical Society; age 69; died June 28, 1975.

Claude C. Farley, M.D., 6400 Prospect, a graduate of the University of Kansas, 1944; member Jackson County Medical Society; age 61; died July 13, 1975.

PRESCRIBING INFORMATION
Antiminth (pyrantel pamoate) Oral Suspension

Actions. Antiminth (pyrantel pamoate) has demonstrated anthelmintic activity against *Enterobius vermicularis* (pinworm) and *Ascaris lumbricoides* (roundworm). The anthelmintic action is probably due to the neuromuscular blocking property of the drug.

Antiminth is partially absorbed after an oral dose. Plasma levels of unchanged drug are low. Peak levels (0.05-0.13μg/ml.) are reached in 1-3 hours. Quantities greater than 50% of administered drug are excreted in feces as the unchanged form, whereas only 7% or less of the dose is found in urine as the unchanged form of the drug and its metabolites.

Indications. For the treatment of ascariasis (roundworm infection) and enterobiasis (pinworm infection).

Warnings. *Usage in Pregnancy:* Reproduction studies have been performed in animals and there was no evidence of propensity for harm to the fetus. The relevance to the human is not known.

There is no experience in pregnant women who have received this drug.

Precautions. Minor transient elevations of SGOT have occurred in a small percentage of patients. Therefore, this drug should be used with caution in patients with pre-existing liver dysfunction.

Adverse Reactions. The most frequently encountered adverse reactions are related to the gastrointestinal system.

Gastrointestinal and hepatic reactions: anorexia, nausea, vomiting, gastralgia, abdominal cramps, diarrhea and tenesmus, transient elevation of SGOT.

CNS reactions: headache, dizziness, drowsiness, and insomnia. Skin reactions: rashes.

Dosage and Administration. *Children and Adults:* Antiminth Oral Suspension (50 mg. of pyrantel base/ml.) should be administered in a single dose of 11 mg. of pyrantel base per kg. of body weight (or 5 mg./lb.); maximum total dose 1 gram. This corresponds to a simplified dosage regimen of 1 cc. of Antiminth per 10 lb. of body weight. (One teaspoonful = 5 cc.)

Antiminth (pyrantel pamoate) Oral Suspension may be administered without regard to ingestion of food or time of day, and purging is not necessary prior to, during, or after therapy. It may be taken with milk or fruit juices.

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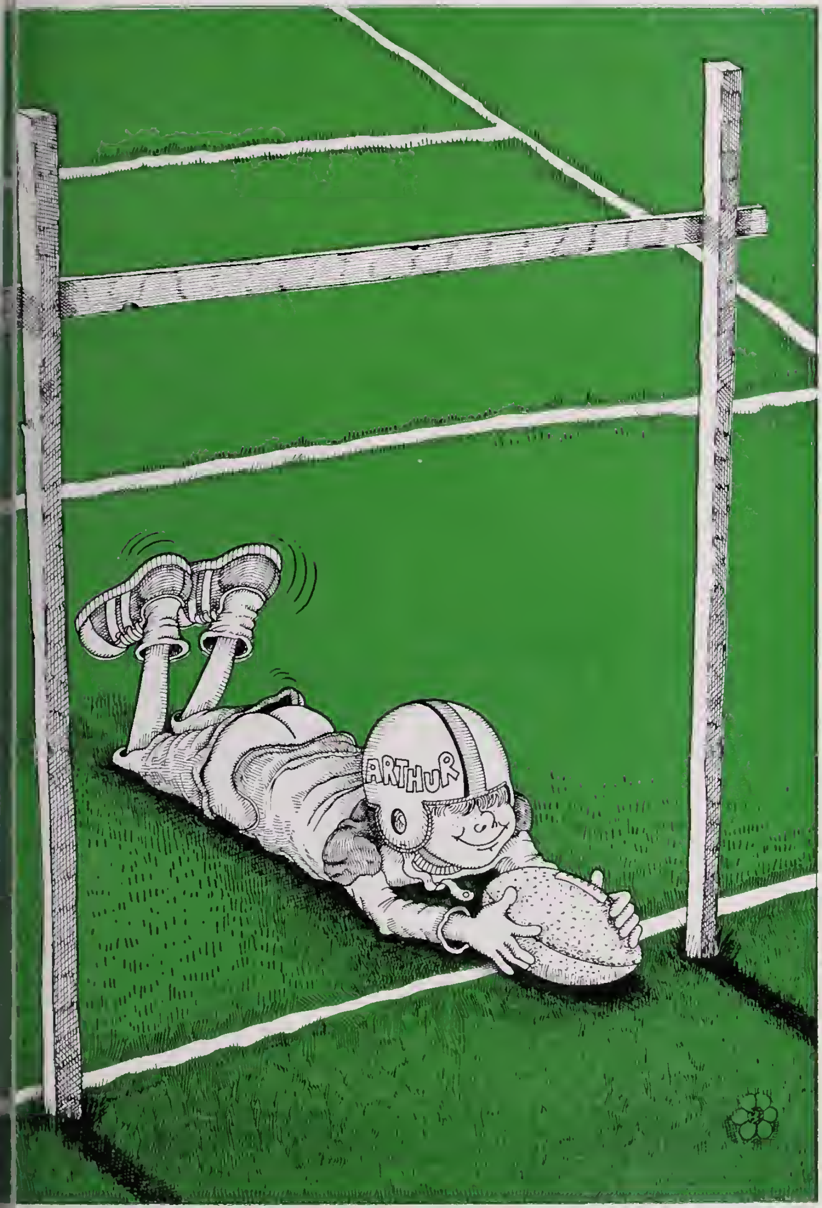

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118th MSMA Annual Session
April 1-4, 1976, Kansas City

Both ofte

Predominant psychoneurotic anxiety
Associated depressive symptoms

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

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Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in f
and/or severity of grand mal seiz
require increased dosage of stan
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addiction-prone individuals unde

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Usual precautions indicated in
everely depressed, or with latent
, or with suicidal tendencies.

Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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Famous Fighters

JOHN L. SULLIVAN
Bare-knuckles heavyweight champion
1882-1892

NEOSPORIN® Ointment
(polymyxin B-bacitracin-neomycin)
is a famous fighter, too.

Provides overlapping, broad-spectrum antibacterial action to help combat infection caused by common susceptible pathogens (including staph and strep).

Each gram contains: Aerosporin® brand Polymyxin B Sulfate 5,000 units; zinc bacitracin 400 units; neomycin sulfate 5 mg (equivalent to 3.5 mg neomycin base); special white petrolatum qs in tubes of 1 oz and 1/2 oz and 1/32 oz (approx.) foil packets.

INDICATIONS: Therapeutically (as an adjunct to systemic therapy when indicated) for topical infections, primary or secondary, due to susceptible organisms, as in: • infected burns, skin grafts, surgical incisions, otitis externa • primary pyodermas (impetigo, ecthyma, sycosis vulgaris, paronychia) • secondarily infected dermatoses (eczema, herpes, and seborrheic dermatitis) • traumatic lesions, inflamed or suppurating as a result of bacterial infection.

Prophylactically, the ointment may be used to prevent bacterial contamination in burns, skin grafts, incisions, and other clean lesions. For abrasions, minor cuts and wounds accidentally incurred, its use may prevent the development of infection and permit wound healing. **CONTRAINDICATIONS:** Not for use in the eyes or external ear canal if the eardrum is perforated. This product is contraindicated in those individuals who have shown hypersensitivity to any of the components. **WARNING:** Because of the potential hazard of nephrotoxicity and ototoxicity due to

neomycin, care should be exercised when using this product in treating
burns, trophic ulceration and other extensive conditions where abso
neomycin is possible. In burns where more than 20 percent of the body
affected, especially if the patient has impaired renal function or is receiv
aminoglycoside antibiotics concurrently, not more than one application
recommended. **PRECAUTIONS:** As with other antibacterial preparations, p
use may result in overgrowth of nonsusceptible organisms, includi
Appropriate measures should be taken if this occurs. **ADVERSE REA**
Neomycin is a not uncommon cutaneous sensitizer. Articles in the curr
ture indicate an increase in the prevalence of persons allergic to neomy
toxicity and nephrotoxicity have been reported (see Warning section).

Complete literature available on request from Professional Services Dept.

Wellcome

Burroughs Wellcome Co.
Research Triangle Park
North Carolina 27709

MSMA

NEWS ROUND - UP

OCTOBER, 1975

Council discusses malpractice issue

'he malpractice insurance situation once again d ninated discussion at the September 12-13 meeting o he MSMA Council in St. Louis.

'he Council commended the Missouri Senate Select C nmittee on Malpractice for its efforts, heard a report o the activities of the Governor's Task Force on M lpractice, received an update on the progress of M ssouri State Medical Insurance, Inc., (MSMI) in the a a of malpractice insurance policies sold, and voted to i estigate the possibilities of setting up a physician-fi- n nced mutual malpractice insurance company.

Vhile commending the Senate Committee, the Coun- c also expressed support in principle of the proposed le islation drafted by the Committee. These include a c ing on awards, limitation of attorney contingent fe s, better Statute of Limitations laws governing m nors, the establishment of malpractice review boards a oss the state and strengthening the policing powers o the Board of Healing Arts.. (See September, M SSOURI MEDICINE.)

)r. Howard J. McAlhany, Council Chairman and M MA's representative on the Governor's Task Force, s d the panel planned to introduce legislation to (1) e ninate the ad damnum clause — the asking of a s cific amount of damages; and (2) set up a statewide r iew panel to review all malpractice cases before they g to court.

Also being considered is legislation which would (1) d ine informed consent, (2) identify the collateral s rce rule, (3) place the contingent fee on a graduated b is, and (4) require that every claim filed be reported t he Missouri Division of Insurance.

t was reported at the Council Meeting that 261 p icies have been sold since MSMI was organized in A ril. Of these, 130 policy holders are in Class I. B ochures detailing the MSMI plan have been mailed t he MSMA membership.

'he Council also voted to "form an Ad Hoc Commit- t to investigate the means and provide framework for e ablishing a mutual insurance company to be wholly o ned and funded by the physicians of Missouri." A re- p t is to be presented at the Annual Session, April 1-4, 1 '6.

Also in the malpractice area, it was reported that the A IA has chartered a re-insurance company and will b in seeking states which would like to participate in t company.

'he Council agreed to a proposal for an MSMI-spon- s ed medical equipment leasing program through the HBE Leasing Corportion. A mailing and brochure will be sent to MSMA members in the near future.

Dr. J. Loren Washburn (left) of Versailles, was presented a plaque for recognition of his 10 years service as a Missouri Delegate to the AMA and 10 years as Alternate Delegate. The presentation was made by Dr. Howard J. McAlhany, Springfield, Chairman of the MSMA Council.

The Council took several actions while discussing the report of the Commission on Medical Economics, Third Party Medicine and Governmental Relations. It was voted to appoint a committee to meet with Missouri Medicaid officials to discuss problems and request a reasonable increase in fees to reflect the current economic conditions.

In addition, the Council was informed that some insurance companies are sending letters to patients whose bills are not completely covered by their policy and telling the patient not to pay the remainder of the bill. The Council voted to immediately inform the insurance companies that such a letter is unethical and should be discontinued.

Later discussion determined that the insurance companies were attempting to establish UCR policies for the physician without the physician's agreement. The Council voted to "take whatever action is necessary, including legal intervention, to preserve the right of the practicing physician to set his fee as an independent

Continued on Next Page

Medical News-in-Brief

Status of Vietnamese physicians

Several MSMA members have asked Headquarters about the status of Vietnamese physicians who fled their country when the Viet Cong took control:

The following statement released by the Missouri Board of Registration for the Healing Arts may answer the questions of those interested members.

"Many communities have recognized the Vietnamese physician as a new resource. At the present, these individuals are being under utilized because they are working as technicians rather than as physicians.

"At the most recent meeting of the State Board of Registration for the Healing Arts, attention was directed toward assisting these physicians to become licensed to practice medicine and thereby help them to realize their full potential.

"There is a clear method to achieve this end. All that is required is that they pass the Flex examination which is given twice a year by the Board. To become eligible to make application for the Flex examination a foreign medical graduate must furnish a copy of his medical school diploma, a permanent certificate from the Educational Council for Foreign Medical Graduates along with one year of approved traning."

Senate Committee hearing set

The next hearing scheduled by the Missouri Senate Select Committee on Malpractice will be held at 10:45 a.m., Wednesday, Nov. 5, at Tan-Tar-A Resort at the Lake of the Ozarks.

The hearing will be held in conjunction with the Annual Convention of the Missouri Hospital Association. Area physicians are encouraged to attend the hearing to gain insight into the malpractice problems and solutions being considered by the Committee.

Sponsored tours scheduled

Two additional tours have been approved the MSMA Council.

The "South China Sea" tour leaves St. Louis a Kansas City on February 7, 1976. Among features of the 14-day air-land vacation are fi nights in Manila, a night in Punta Baluarte a six nights in Hong Kong. Cost of the tour is $1,4

The "South Pacific Adventure," also a 14-d tour, will depart St. Louis and Kansas City March 1, 1976. Highlights of this tour inclu visits to New Zealand, Austrailia and Tahiti. T cost of the tour is $1,468.

Mailings on both tours are being sent to MSMA members, but further information may obtained by contacting MSMA Headquarters.

Clark heads Healing Arts

The Missouri Board of Registration for the Heali Arts has selected Gary R. Clark, Jefferson City, as e ecutive secretary of the board.

Clark replaces John A. Hailey, who retired June 3

Formerly a field representative for Roche Laborat ries, Clark will be responsible for managing the staff the seven-member board which examines and licens about 20,000 physicians and surgeons, as well as phys cal therapists, clinical audiologists and spee pathologists in Missouri.

'M.D. Day' is planned

"M.D. Day" at the University of Missouri-Columbia scheduled November 15.

The scientific program sponsored by the Universi of Missouri and the University of Oklahoma, will held Friday. The Tigers will meet the Sooners in a B Eight football battle on Saturday.

Actions of MSMA Council

Continued

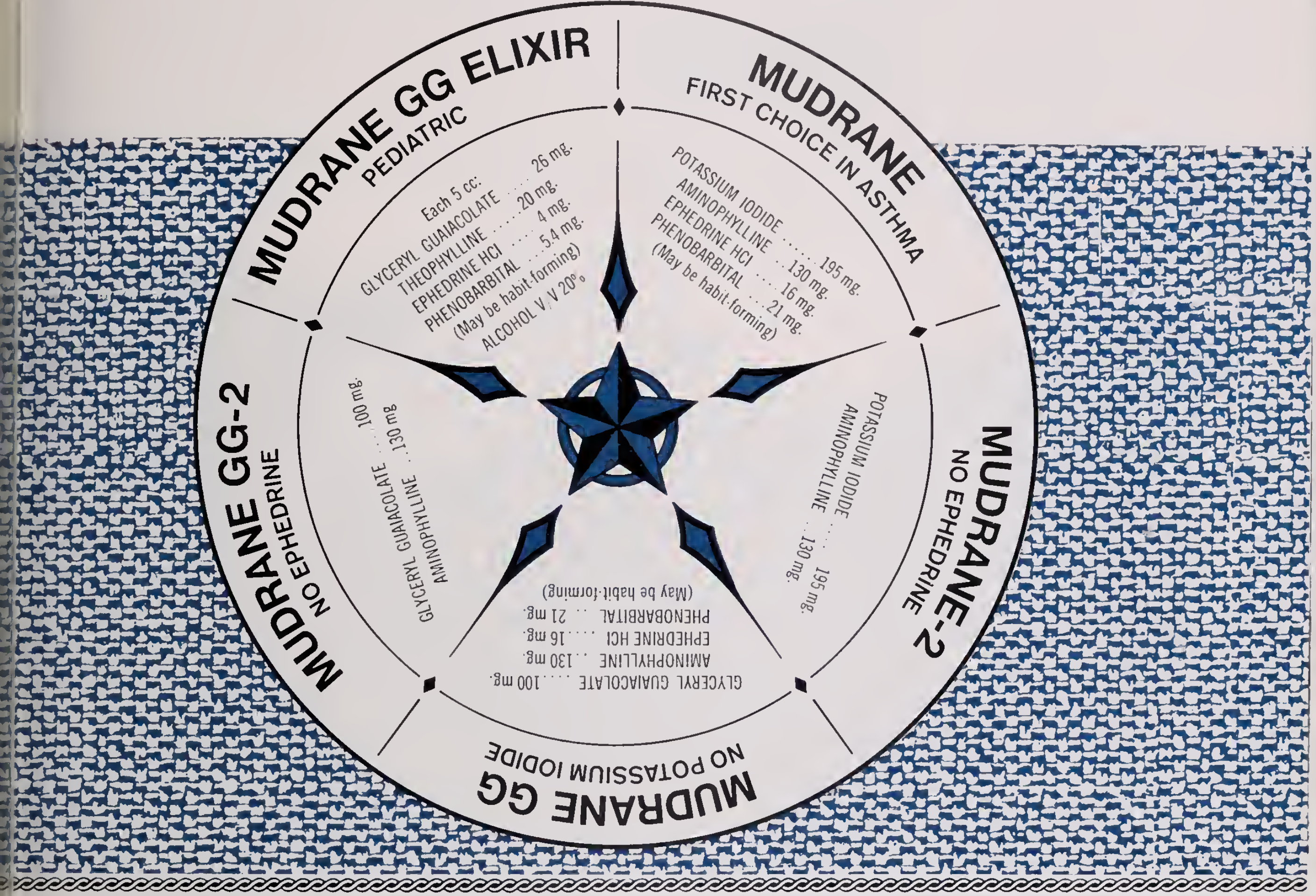
transaction between him and his patient, except where the physician has voluntarily agreed to accept a UCR schedule by signed consent."

In other action, the Council:

- Heard a report of the Committee on Continuing Medical Education which stated that the MSMA has received approval of its CME program from the AMA and can now inspect local hospital programs for accreditation. Fifteen to 20 hospitals across the state have already requested inspection and the Committee is beginning to send out site teams to complete the work.
- Decided to present to the House of Delegates a change in the schedule of Annual Sessions. The proposal calls for the 1976 Session to be in Kansas City, the 1977 Session in St. Louis and the 1978 Session at the Lake of the Ozarks.
- Voted to appoint a committee to work with the Missouri Association of Osteopathic Physicians and Surgeons on legislation and other matters of mutual interest.
- Directed the MSMA executive staff to investigate more effective methods of disseminating legislative information to MSMA members.
- Discussed the organizational meetings being he in each of five Health Service Areas in Missouri ar urged the participation of Missouri physicians in the e tablishment of Health Service Agencies. These age cies will replace the current CHP, RMP and Hill-Burt programs and will place additional planning power the hands of the new agencies.
- Accepted for information a report of the PSR Data Task Force and Missouri Center for Healt Statistics Task Force.
- Agreed with Dr. R. Allen Chandler, MSMA Pres dent, on the re-appointment of Dr. Clem Grebel as th MSMA representative to the PSRO Support Center.
- Was informed by Mrs. William McPhee, Preside of the MSMA Auxiliary, that more than 1,400 MSM members are participating in the Immunization Actio Month program. Members have ordered more tha 192,000 brochures to be mailed to their patients. Als the Auxiliary has scheduled its Fall Conference for Oc 22-23 in Sedalia. In a motion, the Council expressed it appreciation to the Auxiliary for the assistance it ha provided the physicians of Missouri.
- Heard a report that the Missouri Cancer Pr grams, Inc., has been established to coordinate effort of various cancer programs in Missouri.

The MUDRANES

Discreet formulations of four well regarded drugs for the relief of bronchial distress—Potassium Iodide, Glyceryl Guaiacolate, Aminophylline, Ephedrine with Phenobarbital (to lessen cardiac stimulation).


MUDRANE GG ELIXIR
PEDIATRIC
Each 5 cc:
GLYCERYL GUAIACOLATE .... 26 mg.
THEOPHYLLINE ..... 20 mg.
EPHEDRINE HCl .... 4 mg.
PHENOBARBITAL .... 5.4 mg.
(May be habit-forming)
ALCOHOL V/V 20%
MUDRANE
FIRST CHOICE IN ASTHMA
POTASSIUM IODIDE ..... 195 mg.
AMINOPHYLLINE ..... 130 mg.
EPHEDRINE HCl .... 16 mg.
PHENOBARBITAL .... 21 mg.
(May be habit-forming)
MUDRANE-2
NO EPHEDRINE
POTASSIUM IODIDE ..... 195 mg.
AMINOPHYLLINE .. 130 mg.
MUDRANE GG
NO POTASSIUM IODIDE
GLYCERYL GUAIACOLATE .... 100 mg.
AMINOPHYLLINE .. 130 mg.
EPHEDRINE HCl ..... 16 mg.
PHENOBARBITAL .. 21 mg.
(May be habit-forming)
MUDRANE GG-2
NO EPHEDRINE
GLYCERYL GUAIACOLATE ..... 100 mg.
AMINOPHYLLINE .. 130 mg

INDICATIONS: For the prompt symptomatic relief of bronchial asthma, emphysema and bronchiectasis. The Mudranes dilate the bronchi and liquefy mucus plugs. DOSAGE: Tablet; One tablet with a full glass of water 3 or 4 times daily as required. Divide tablet for child's dose. Elixir; Children, 1 cc for each 10 lbs. of body weight. May be repeated 3 or 4 times a day. Adult, one tablespoonful 4 times daily. All doses should be followed with a glass of water.

CONTRAINDICATIONS: Aminophylline/Theophylline is contraindicated in the presence of severe cardiac arrhythmias and patients with massive myocardial damage. Ephedrine, in presence of severe heart disease, extreme hypertension, and in hyperthyroidism. Phenobarbital, in porphyria and in patients with known phenobarbital sensitivity. Potassium Iodide, in pregnancy (to protect the fetus against possible iodine-induced depression of thyroid activity), in tuberculosis (produces gumma dissolution), and in acne; also in the presence of known iodide sensitivity. PRECAUTIONS: Aminophylline/Theophylline should be avoided in patients with massive myocardial damage and/or severe cardiac arrhythmias. In children, overdose may cause vomiting, cardiac arrhythmias, and severe agitation. Ephedrine should be used with caution in the presence of severe cardiac disease, particularly arrhythmias and angina pectoris; avoid in hyperthyroidism and severe hypertension. Phenobarbital may be habit-forming. Avoid overdosage. Potassium Iodide: Discontinue in the presence of skin rash, swelling of the eyelids and severe frontal headache. Long use may cause goiter. ADVERSE REACTIONS: Aminophylline/Theophylline may cause nausea, cardiac arrhythmias, and aggravate severe myocardial disease. It may cause headaches and tachycardia. Vomiting and dizziness are not uncommon. Ephedrine: In patients hypersensitive to CNS stimulation, ephedrine may cause nervousness, tachycardia, extrasystole and ventricular arrhythmias. May cause urinary retention, especially in the presence of partial prostatic obstruction. Psychoneurosis may be aggravated. Pre-existing anginal pain will be aggravated. Phenobarbital may produce severe skin rash. Avoid overdosage. May be habit-forming. Potassium Iodide may cause nausea. Over very long period of use, iodides cause goiter. Discontinue if patient develops skin rash, eye irritation, eyelid swelling, or severe frontal headache.

HOW SUPPLIED: Mudrane and Mudrane GG available in bottles of 100 and 1000 tablets; Mudrane-2 and Mudrane GG-2 in 100s; Elixir in pints and half-gallons.

Federal law prohibits dispensing without prescription.

WILLIAM P. POYTHRESS & COMPANY, INC., RICHMOND, VIRGINIA 23261

There's something special about children vomi in

The risk of dehydration . . . plus the psycholog al stress on both mother and child . . . greatly increases the urgency in controlling v it in children. In addition, there is, of course, nee to avoid the extrapyramidal problems associated it phenothiazine medications.

at's why special medication is preferred

S® CHILDREN SUPPRETTES™ are specially
mlated to stop vomiting and nausea in children—
y and with minimal complications.

NS are administered rectally—often the best
n the vomiting patient.

exclusive WANS formula provides both
nine maleate and sodium pentobarbital for
veness . . . contains no phenothiazines or local
etics.

unique Supprette delivery system rapidly
es effective levels of medication . . . with no
fatty acids to affect absorption or cause local
on.

NS SUPPRETTES require no refrigeration . . .
rication other than water . . . and dissolve
etely, with virtually no leakage.

r children over 12 years of age and adults
ng from nausea and vomiting, consider higher-
th WANS® No. 1 or WANS® No. 2.

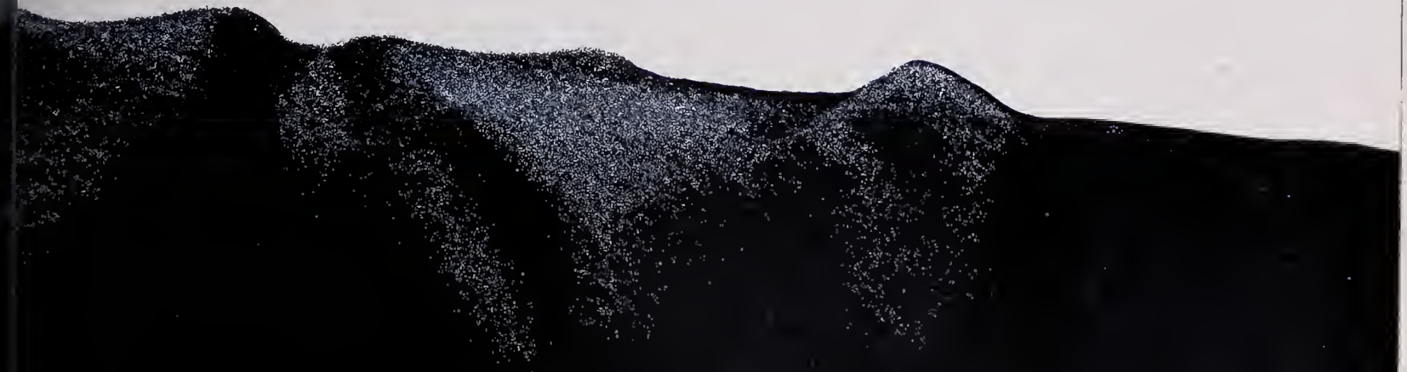
A special favorite* of Missouri physicians in controlling childhood vomiting

WANS® CHILDREN SUPPRETTES™

rectal antinauseant/antiemetic

pyrilamine maleate 25 mg; sodium pentobarbital 30 mg
Warning: may be habit forming

*Based on usage by dosage form; data gathered by independent research organization.



RIPTION: WANS® Children: (Blue) pyrilamine maleate
and pentobarbital sodium* ½ gr (30 mg) scored for
ge. WANS® No. 1: (Pink) pyrilamine maleate 50 mg
tobarbital sodium* ¾ gr (50 mg) scored for ½ dosage.
® No. 2: (Yellow) pyrilamine maleate 50 mg and
arbital sodium* 1½ gr (100 mg) scored for ½ dosage.

NING: may be habit forming.

AINDICATIONS: Infants under 6 months. Acute
ttent porphyria, known hypersensitivity to barbiturates
istamines, known previous barbiturate addiction,
hepatic impairment, CNS injury, senility, and presence
ntrolled pain.

INGS: Barbiturates may be habit forming. Pre-existing
logic disturbances may be aggravated. Idiosyncratic
ns may occur. Acquired sensitivity may result in allergic
ns. Safety in pregnancy has not been established.

UTIONS: Use cautiously with other sedative, hypnotic
tic agents. Use with caution in patients with acute or
hepatic disease, fever, hyperthyroidism, diabetes
s, severe anemia, congestive heart failure, or a history
dependence or suicidal tendencies. May impair
ss and coordination with increased accident risk.

ADVERSE REACTIONS: Drowsiness, fatigue, vertigo, incoordination, tremor, muscle weakness, ataxia, hypotension, respiratory depression, delirium and coma. Dryness of nose, mouth, and throat, pupillary dilatation or blurred vision, urinary retention, abdominal pain, nausea, vomiting, diarrhea, and hypersensitivity reactions. Overdose may result in hallucinations, excitement, ataxia, incoordination, athetosis, convulsions, and death.

DOSAGE AND ADMINISTRATION: Rectally, children 2-12 years of age, one WANS® CHILDREN every 6-8 hours as required. Children under 2 years of age may receive ½ the above dosage. *Adults:* Rectally, one WANS® No.1 Supprette™ to inhibit mild nausea and/or vomiting; one WANS® No. 2 Supprette to control pernicious vomiting. Repeat doses for adults should be 4 to 6 hours apart, not to exceed four doses in 24 hours. Moisten finger and Supprette with water before inserting. Optimum dosage must be determined in each case by the clinical response.

WEBCON

Webcon Pharmaceutical Division
Alcon Laboratories, Inc.
Fort Worth, Texas 76101

medical melange

Notes of interest from Here . . . . and Ther

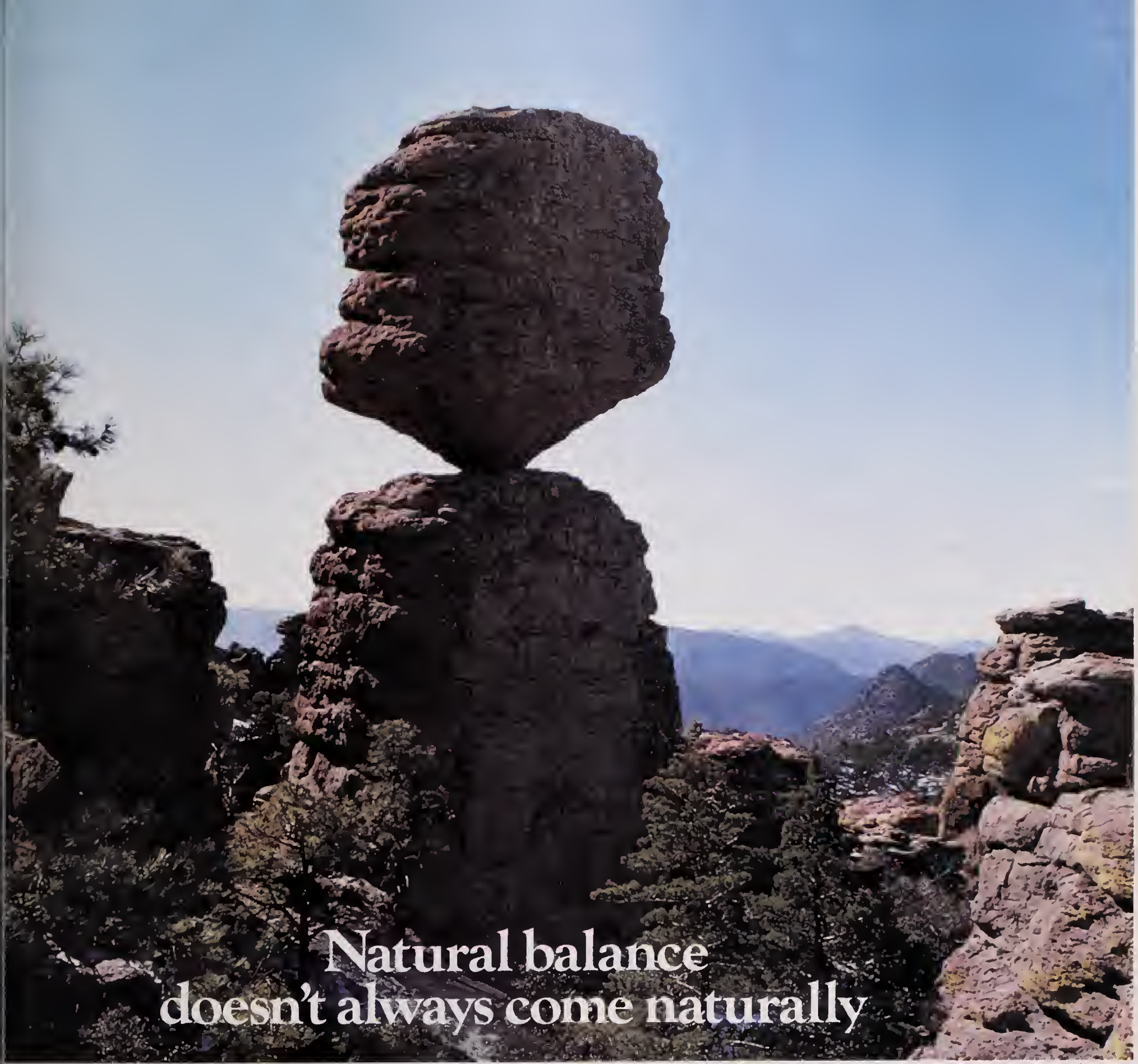
Area and statewide representatives of the mental health community gathere in Farmington on August 22 to pay tribute to Dr. **Emmett F. Hoctor** on th occasion of his 79th birthday and his 50th year of service to the Farmingto State Hospital. **Mr. Bill Blair**, administrator of the Farmington Community Ho pital, presented a bronze plaque to Dr. Hoctor from the Chamber of Commerc on behalf of the City. Dr. **Harold Robb**, director of the Missouri Department Mental Health, gave Dr. Hoctor a 50-year state service award pin. A scroll an picture of the hospital's Administration Building was presented to him by **D Jay Tuttle**, superintendent of the State Hospital. **Mr. Jack Stapleton, Jr.**, a Ke nett newspaper publisher and vice-chairman of the Department of Mental Healt was master of ceremonies.

Gov. Christopher Bond has appointed **Dr. James M. Whittico, Jr.** of St. Louis as a member of the State Board of Registration for the Healing Arts for a term ending Sept. 3, 1979. Dr. Whittico served as president of the National Medical Association in 1968-1969. In addition to his private practice in St. Louis, he is a medical consultant to the U. S. Department of Health, Education and Welfare, a surgeon for the St. Louis Metropolitan Police Department and an instructor at the St. Louis University School of Medicine. Dr. Whittico is a member of the Board of Trustees Committee on Health Care of the Poor of the American Medican Medical Association.

Sunday, September 7, was proclaimed "Dr. **R. Lee Cooper Day**" in Warrens burg by **Mayor Howard Chappell** and the **Johnson County Medical Auxiliar** hosted an open house honoring Dr. and Mrs. Cooper. Dr. Cooper closed hi office doors after 41 years of serving his community as a doctor in general practic and surgery. Dr. Cooper received his M.D. degree from Washington Universit School of Medicine in 1933. He served as Vice-President of the MSMA in 1973 1974. His participation in many civic affairs included service as a member of th City Council. He was a member of the Board of Regents of Central Missour State College from 1942 until 1951, a charter member of the Lions Club i Warrensburg and is a member of the Order of Masons and Houn Dawg Shrine o the Ararat Temple in Kansas City. Dr. and Mrs. Cooper have two children: **Mrs Hugh (Joan) Hanna** and **Dr. Robert L. Cooper II**, both of Warrensburg.

Dr. Windsor B. Atcheson of Trenton has accepted a position with the U. S. Department of Health, Education and Welfare in the Washington, D. C. area. He is working in a clinic operated by the Army Institute of Cancer Research.

Approximately 100 persons who are employed in the Veterans of Foreign War national headquarters building in Kansas City held a surprise party for thei resident doctor, Dr. **James R. McVay, Sr.** in celebration of the 50th year in whic Dr. McVay has practiced medicine in the building. Dr. McVay, who graduated from the University of Missouri in 1912 and the Johns Hopkins University Schoo of Medicine in 1915, has served as President of the Missouri State Medical Association, as a trustee of the American Medical Association and as Chairman o the Council of Medical Services of the AMA.



Big Balanced Rock, Chiricahua Mountains, Arizona (approx 1,000 tons)

nd useful in the management of vertigo* associated with es affecting the vestibular system.

relieve nausea and vomiting often associated with vertigo.*

al adult dosage for Antivert/25 for vertigo:* one tablet t.i.d.

available as Antivert (meclizine HCl) 12.5 mg. scored s, for dosage convenience and flexibility.

ivert/25 (meclizine HCl) 25 mg. *Chewable* Tablets for a, vomiting and dizziness associated with motion sickness.

UMMARY OF PRESCRIBING INFORMATION

ICATIONS. Based on a review of this drug by the National Academy of ces—National Research Council and/or other information, FDA has classified dications as follows:

ective: Management of nausea and vomiting and dizziness associated with on sickness.

sibly Effective: Management of vertigo associated with diseases affecting the ular system.

al classification of the less than effective indications requires further tigation.

CONTRAINDICATIONS. Administration of Antivert (meclizine HCl) during pregnancy or to women who may become pregnant is contraindicated in view of the teratogenic effect of the drug in rats.

The administration of meclizine to pregnant rats during the 12-15 day of gestation has produced cleft palate in the offspring. Limited studies using doses of over 100 mg./kg./day in rabbits and 10 mg./kg./day in pigs and monkeys did not show cleft palate. Congeners of meclizine have caused cleft palate in species other than the rat.

Meclizine HCl is contraindicated in individuals who have shown a previous hypersensitivity to it.

WARNINGS. Since drowsiness may, on occasion, occur with use of this drug, patients should be warned of this possibility and cautioned against driving a car or operating dangerous machinery.

Usage in Children: Clinical studies establishing safety and effectiveness in children have not been done; therefore, usage is not recommended in the pediatric age group.

Usage in Pregnancy: See "Contraindications."

ADVERSE REACTIONS. Drowsiness, dry mouth and, on rare occasions, blurred vision have been reported.

More detailed professional information available on request.

ROERIG Pfizer
A division of Pfizer Pharmaceuticals
New York, New York 10017

Antivert®/25
(meclizine HCl) 25 mg. Tablets
for vertigo*

Opinion & Dialogue

Should a specially prepared package insert be made available to patients?

Dr. Alexander M. Schmidt
Commissioner,
Food and Drug
Administration

The idea of a so-called pati
package insert has been arounc
a long time. Many physicians alr
use written instruction sheets tc
provide patients with informatic
about the drugs they are taking.
some physicians give verbal ins
tions; but in too many instances
these are what I call eye-glazing
ercises. I have seen patients sit
glazed eyes listening to a rapid-
lecture by a hurried physician w
has 20 people out in his waiting
room. These patients aren't give
sufficient understanding and th
fore do not follow instructions. S
think the idea of an official pack
insert for patients is a good one.
Perhaps we should really think c
this kind of information simply a
extension of drug labeling.

The benefits of patient involveme

Many physicians may not r
ize how frequently a patient obta
his drug information from Aunt
Tillie or the next door neighbor.
this information is almost alwa
bad or irrelevant to the case at h
Furthermore, the incentive to gc
along with a prescribed program
slim if the only reading matter th
patient receives, along with his p
scription, is a bill.

As an educator I am impres
by the principle that the best way
get someone to do something is
involve him in the process. So th

Dr. James H. Sammons
Executive Vice President
of the American
Medical Association

I think there are advantages
well as some real disadvantages
a patient package insert. When y
begin to use semi-medical or me
cal terms to describe complicati
or possible sequelae of disease o
treatment, you may frighten the
tient—particularly since the mor
highly sophisticated patient is nc
the one who is going to read the i
sert. The patient who will read it i
the one most susceptible to frigh
and confusion by the language.

On the positive side, a pack
insert will probably give the patie
better insight into why he is bein
treated the way he is, and it may
give the physician a little bit mor
time. But it does not remove fron
the physician the need or obligat
to explain the insert.

Some pitfalls in the inclusion of side effects

Certainly a patient should b
warned of the possibility of seriou
side reactions—to know what the
real dangers are. But it doesn't d
bit of good to indicate that a patie
on oral penicillin may develop a
rash, itching, or a drop in blood
pressure. Or that he may faint. I
think the real danger is that frigh
engendered by the insert may pos
sibly outweigh the potential good

main purpose of drug information for the patient is to get his cooperation in following a drug regimen.

Preparation and distribution of patient drug information

We would hope to amass information from physicians, medical societies, the pharmaceutical industry and centers of medical learning. The ultimate responsibility for uniform labeling must, however, rest with the Food and Drug Administration. There is nothing wrong with this agency saying, "this information is generally agreed upon and therefore it should be used," as long as our process for getting the information is sound.

Distribution of the information is a problem. In great measure it would depend on the medication in question. For example, in the case of an injectable long-acting progesterone, we would think it mandatory to issue two separate leaflets—a short one for the patient to read before getting the first shot and a long one to take home in order to make a decision about continuing therapy. In this case, the information might be put directly on the package and not removable at all. But for a medication like an antihistamine this information might be issued separately, thus giving the physician the option of distribution. This could preserve the placebo use, etc.

It is in the distribution of patient information that the pharmacist may get involved. As professionals and members of the health-care team and as a most important source of drug information to patients, pharmacists should be responsible for keeping medical and drug records on patients. It is also logical that they should distribute drug information to them.

Realistic problems must be considered

We have to expect that the introduction of an information device will also create new problems. First, how can we communicate complex and sophisticated information to people of widely divergent socioeconomic and ethnic groups? Second, what will we say? And third, how can we counteract the negative attitude of many physicians toward any outside influence or input? Hopefully the medical profession will respond by anticipating the problems and helping to solve them. Assuming we can also solve the difficulty of communicating information to diverse groups throughout the United States, our remaining task will be the inclusion of appropriate material.

What information is appropriate?

In my opinion, technical, chemical and such types of material should not be included. And there is no point in the routine listing of side effects like nausea and vomiting which seem to apply to practically all drugs, unless it is common with the drug. However, serious side effects should be listed, as should information about a medication that is potentially risky for other reasons.

Other pertinent information might consist of drug interactions, the need for laboratory follow-up, and special storage requirements. What we want to include is information that will help increase patient compliance with the therapy.

Positive aspects of patient drug information

Labeling medication for the patient would accomplish a number of good things: the patient could be on the lookout for possible serious side effects; his compliance would increase through greater understanding; the physician would be a better source of information since he would be freer to use his time more effectively; other members of the health-care team would benefit through patient understanding and cooperation; and, finally, the physician-patient relationship would probably be enhanced by the greater understanding on the part of the patient of what the physician is doing for him.

Only the doctor can remove that fear by 20 or 30 minutes of conversation.

I'm not suggesting that we withhold any information from the patient because, first of all, it would be totally dishonest and secondly, it would defeat the very purpose of the insert. I do think that a patient on the birth control pill should know about the incidence of phlebothrombosis.

If you're going to tell a patient the incidence of serious adverse reactions, then you have to tell him that a concerned medical decision was made to use a particular medication in his situation after careful consideration of the incidence of complications or side effects.

Emotionally unstable patients pose a special problem

There are patients who, because of severe emotional problems, could not handle the information contained in a patient package insert. Yet if we are going to have a package insert at all, we just can't have two inserts. I think we might simply have to tell the families of these patients to remove the insert from the package.

Legal implications of the patient package insert

Just what effect would a patient package insert have on malpractice? We could try to avoid any legal implications by pointing out that the physician has selected a particular medication because, in his professional judgment, it is the treatment of choice. For instance, you can't tell everyone taking antihistamines not to work just because a few patients develop extreme drowsiness which can lead to accidents. And what about the very small incidence of aplastic anemia rarely associated with chloramphenicol? If, based on sensitivity studies and other criteria, we decide to employ this particular antibiotic, we do so in full knowledge of this serious potential side effect. It's not a simple problem.

How do we handle an insert for medication used for a placebo effect?

With rare exceptions, physicians no longer use medications for a placebo effect. This question does raise the issue of how a patient may react to receiving a medication without a package insert.

Preparation of the package insert

The development of the insert ought to be a joint operation between physicians, the pharmaceutical industry, the A.M.A. and the F.D.A.

I view the A.M.A.'s role as a coordinator or catalyst. It is the only organization through which the profession as a whole, irrespective of specialty, can speak. It has relatively instant access to all the medical expertise in this country. And it can bring that professional expertise together to ensure a better package insert. The A.M.A. can work in conjunction with the industry that has produced the product and which is ultimately going to supply the insert.

I don't think we should rely, or expect to rely, on legislative committees and their nonprofessional staffs to make these decisions when it is perfectly within the power of the two groups to resolve the issues in the very best American tradition—without the government forcing us to do it. I think the F.D.A. has to be involved, but I'd like them to become involved because they were asked to become involved.

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* WARNING
This fixed combination drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual patient. If the fixed combination represents the dosage so determined, its use may be more convenient in patient management. The treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

* Indications: *Edema:* That associated with congestive heart failure, cirrhosis of the liver, the nephrotic syndrome; steroid-induced and idiopathic edema; edema resistant to other diuretic therapy. *Mild to moderate hypertension:* Usefulness of the triamterene component is limited to its potassium-sparing effect.

Contraindications: Pre-existing elevated serum potassium. Hypersensitivity to either component. Continued use in progressive renal or hepatic dysfunction or developing hyperkalemia.

Warnings: Do not use dietary potassium supplements or potassium salts unless hypokalemia develops or dietary potassium intake is markedly impaired. Enteric-coated potassium salts may cause small bowel stenosis with or without ulceration. Hyperkalemia (>5.4 mEq/L) has been reported in 4% of patients under 60 years, in 12% of patients over 60 years, and in less than 8% of patients overall. Rarely, cases have been associated with cardiac irregularities. Accordingly, check serum potassium during therapy, particularly in patients with suspected or confirmed renal insufficiency (e.g., elderly or diabetics). If hyperkalemia develops, substitute a thiazide alone. If spironolactone is used concomitantly with 'Dyazide', check serum potassium frequently—both can cause potassium retention and sometimes hyperkalemia. Two deaths have been reported in patients on such combined therapy (in one, recommended dosage was exceeded; in the other, serum electrolytes were not properly monitored). Observe patients on 'Dyazide' regularly for possible blood dyscrasias, liver damage or other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving Dyrenium (triamterene, SK&F). Rarely, leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with the thiazides. Watch for signs of impending coma in acutely ill cirrhotics. Thiazides are reported to cross the placental barrier and appear in breast milk. This may result in fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly other adverse reactions that have occurred in the adult. When used during pregnancy or in women who might bear children, weigh potential benefits against possible hazards to fetus.

Precautions: Do periodic serum electrolyte and BUN determinations. Do periodic hematologic studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in postsympathectomy patients. The following may occur: hyperurice
and gout, reversible nitrogen retention, decre
alkali reserve with possible metabolic acidosis, hyp
glycemia and glycosuria (diabetic insulin requ
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hypokalemia). Use cautiously in surgical patie
Concomitant use with antihypertensive agents
result in an additive hypotensive effect. 'Dyazi
interferes with fluorescent measurement
quinidine.

Adverse Reactions: Muscle cramps, weakness,
ziness, headache, dry mouth; anaphylaxis; ra
urticaria, photosensitivity, purpura, other derr
tological conditions; nausea and vomiting (may
dicate electrolyte imbalance), diarrhea, constipati
other gastrointestinal disturbances. Necrotiz
vasculitis, paresthesias, icterus, pancreati
xanthopsia and, rarely, allergic pneumonitis h
occurred with thiazides alone.

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Donnagel with paregoric equivalent

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Pectin	142.8 mg.
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Atropine sulfate	0.0194 mg.
Hyoscine hydrobromide	0.0065 mg.
Powdered opium, USP (equivalent to paregoric 6 ml.) (warning: may be habit forming)	24.0 mg.
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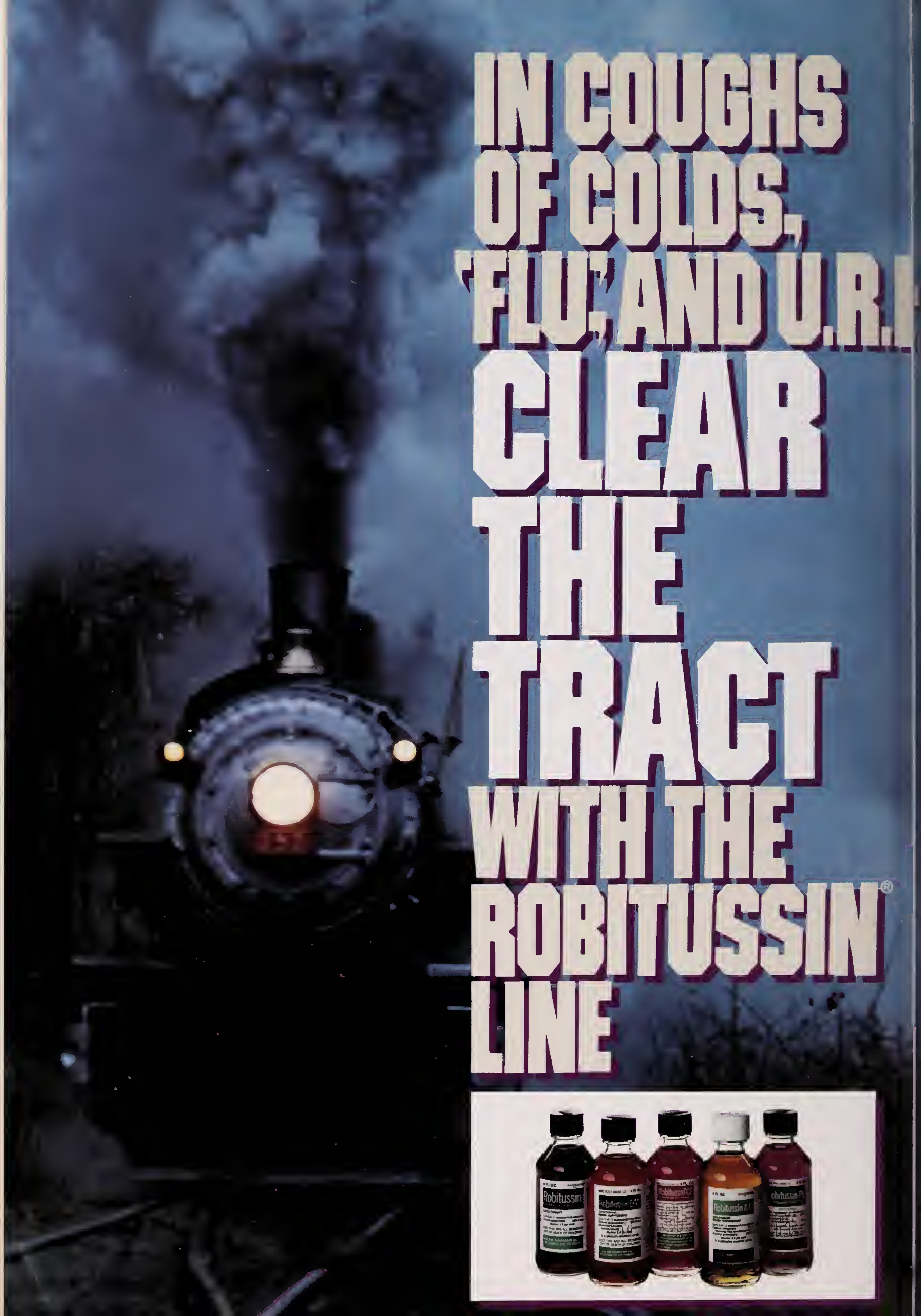
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TRACT
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*fmerly named Glyceryl Guaiacolate

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Immunization Action Month—

Report of a Measles Outbreak in St. Louis County

By

Betty P. Carlin, M.D. and
Shelley S. Sansbury, Jr., M.S.P.H.

October has been designated as Immunization Action Month by the Center for Disease Control in an effort to call physicians' and parents' attention to declining levels of immunization and to stimulate community action to increase these levels. National surveys indicate that approximately 5.3 million of the nearly 13.2 million 1-to-4-year-old children are unprotected against either polio, measles, rubella, diphtheria, pertussis or tetanus. Although there have been no cases of poliomyelitis or diphtheria in St. Louis County for many years, pertussis does occur sporadically and measles and rubella continue to occur in unwelcome numbers.

This study of a recent outbreak of measles in St. Louis County, a relatively affluent area where health care, including immunizations, is provided largely by private physicians, demonstrates that there are a significant number of children who not immunized against measles and that both p ents and physicians need to intensify their vigilar to see that all children receive protection agai measles and other vaccine preventable diseases

Between January and June in 1975, a total of cases of measles was reported to the St. Lo County Health Department.

Tables 1, 2 and 3 show reported cases of meas by year from 1966 to 1975 and by age group a vaccination status in 1975.

TABLE 1

REPORTED CASES OF MEASLES BY YEAR 1966-1975

Year	*No. Reported Cases*
1966	21
1967	28
1968	0
1969	10
1970	18
1971	448
1972	91
1973	1
1974	25
1975 (to June)	77

TABLE 2

REPORTED CASES OF MEASLES BY AGE GROUP 1975

Age	*No. Reported Cases*	*Est. County Population (1974)*
Under 1 Year	0	15,552
1-4 Years	12	65,124
5-9 Years	33	102,060
10-14 Years	23	108,864
15-18 Years	9	75,816

Vaccinated Children are those whose histories vaccination were confirmed by a telephone call the doctor's office or from a doctor's record giv to the mother. The number of children (13) w were vaccinated when under one year of age a who did not receive an additional dose of vacci is a distressing finding. The American Academy Pediatrics recommends that if measles vaccine given before a child is 12 months of age, a secon dose should be given at 12 to 16 months of a because the rate of seroconversion prior to age months is variable. The fact that 17 children wh received measles vaccine over 1 year of age an subsequently, became ill with the disease shou not lead to the conclusion that the vaccine is n effective. Vaccine failures are to be expected sin seroconversion may not occur in 5% of susceptib children given measles vaccine at age 1 year older. Further, improper storage of vaccine, suc as allowing it to warm, may cause the virus become inactivated.

Unvaccinated Children are those whose paren

TABLE 3

REPORTED CASES OF MEASLES BY VACCINATION STATUS 1975

No. Cases Vaccinated	
Vaccinated Under 1 Year	13
Vaccinated at 1 Year and Over	17
No. Cases Not Vaccinated	
No. Cases Vaccination Unknown	1

r doctor or both reported no vaccination and for hom no record could be found elsewhere (school, inic, immunization registry, etc.). Most of the unaccinated children received their health care from rivate physicians and some parents assumed their hildren had received "all necessary shots."

Vaccination Status Unknown are those children hose parents were uncertain about vaccination or ported vaccination from a doctor elsewhere who uld not be located.

Although measles is a reportable disease in St. uis County, compliance is mediocre at best. An timated 30% of the cases are reported. Most cases ere initially reported by a school nurse and only ose diagnosed by a physician and having signs d symptoms consistent with a clinical diagnosis measles are included here. Clinical criteria for diagnosis of measles were at least two days of odromal symptoms (cough, coryza, fever), folwed by a rash of at least five days' duration assoated with a fever of equal to or greater than 2 F (38.9 C). Signs and symptoms reported most equently were cough, coryza, sore throat, Koplik ots, high fever and rash lasting five to eight days. striking feature of this outbreak reported by both rents and doctors was the severity of illness. Four tients were hospitalized as follows.

A 6-year-old boy developed encephalitis but has no residual neurologic damage. He had received Edmonston Strain Vaccine with immune serum globulin at 8 months of age.

. A 14-year-old girl reported ten days after onset with a possible case of typhoid fever with pneumonia. Two weeks after onset of illness in the patient, her twin became ill with a similar but less severe illness. Paired acute and convalescent sera from this twin showed a rise in measles titer from 1:8 to 1:64. The mother stated that the twins received two doses of vaccine about a month apart when they were approximately 1 year old but did not keep an appointment for a third dose scheduled a month later. This history of vaccination could not be confirmed because the doctor could not be located but it was assumed to be inactivated vaccine.

An 18-year-old girl was hospitalized because of severity of illness. Paired sera showed a rise in measles titer from 1:8 to 1:64.

4 A 14-year-old girl hospitalized again because of severity of illness had a paired sera with a rise in measles titer from 1:8 to 1:64. Neither of these two patients had a definite history of vaccination.

October again has been designated as Immunization Action Month. A variety of educational and promotional activities are being coordinated by the St. Louis County Center for Disease Control in an effort to reverse the trend toward declining immunization levels among children in recent years.

Vaccine-preventable diseases have not been entirely eradicated as indicated in the accompanying article. Analysis showed that at least 44% (34) of the measles cases occurred among unimmunized children, while 17% (13) cases occurred among children who may have been inadequately immunized because they received vaccine prior to 1 year of age.

Although primarily a report of an epidemiologic investigation, this study illustrates the need for more intensified efforts to raise the levels of immunization against measles and other vaccine-preventable diseases.

Dr. Carlin is from the School Health Section and Mr. Sansbury is from the Communicable Disease Section, Department of Community Health and Medical Care, St. Louis County.

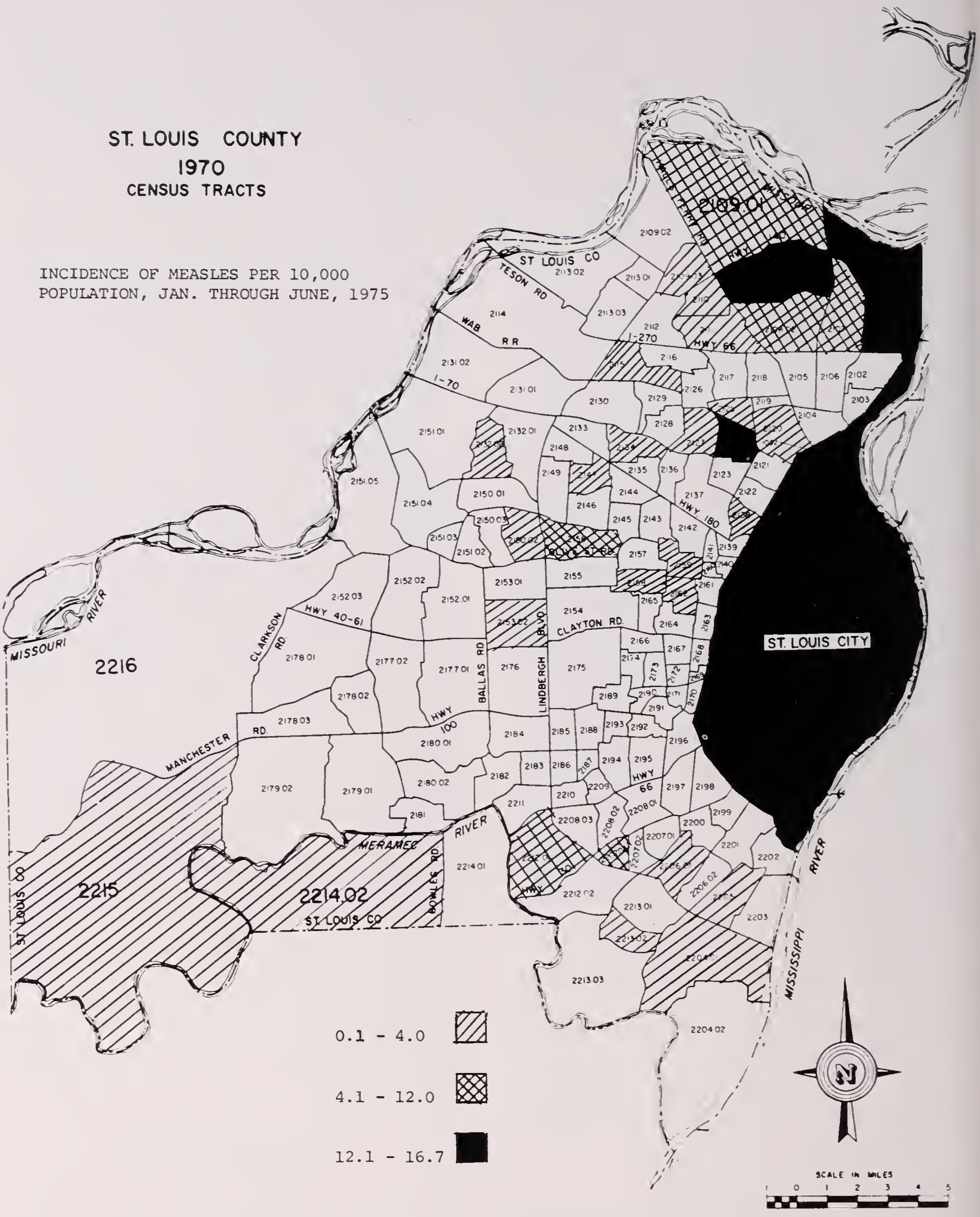
Prior to the middle of April, cases were scattered throughout the county. The report of a case on April 24, 1975 with an onset date of April 17 was rapidly followed by a definite clustering of cases in an area in the northeastern section of the county comprising a large school district and involving three elementary schools, a junior and senior high school and a nursery school. See Fig. 1 and Fig. 2, which shows measles case by date of onset.

The case reported on April 24 was that of a 6-year-old boy in the kindergarten class of Elementary School T. A survey of immunization records of children showed that all but three had been vaccinated after 1 year of age.

Following is an account of subsequent cases in this school district:

Elementary School T Enrollment 848	
Kindergarten	7
Grade 1	2
Grade 2	2
Grade 4	2
Total Cases	13

Of the 13 children, eight were vaccinated, five of whom were under 1 year of age. Of five unvaccinated children, two had parents who had religious


ST. LOUIS COUNTY
1970
CENSUS TRACTS
INCIDENCE OF MEASLES PER 10,000
POPULATION, JAN. THROUGH JUNE, 1975
0.1 - 4.0 ▨
4.1 - 12.0 ▦
12.1 - 16.7 ■
ST LOUIS CITY
ST LOUIS CO
MISSOURI RIVER
MISSISSIPPI RIVER
MERAMEC RIVER
TESON RD
WAB RR
I-270
I-70
HWY 66
HWY 180
HWY 40-61
HWY 100
CLARKSON RD
MANCHESTER RD.
BALLAS RD
LINDBERGH BLVD
CLAYTON RD
BOWLES RD
2216
2215
2214.02
2214.01
2109.01
2109.02
2113.02
2113.01
2113.03
2114
2112
2131.02
2131.01
2151.01
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2152.02
2152.03
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2142
2123
2122
2121
2157
2155
2154
2165
2164
2166
2167
2189
2191
2192
2193
2194
2195
SCALE IN MILES
1 0 1 2 3 4 5
N

EAST WEST GATEWAY COORDINATING COUNCIL

Fig. 1

MEASLES CASES BY DATE OF ONSET, JAN. TO JUNE, 1975

ST. LOUIS COUNTY, MISSOURI

T	Elementary School
J	Elementary School
L	Elementary School
h	Junior High School
H	High School
N	Nursery School
P	Preschool Child
*	St. Lóuis County
x	Immunization Clinic

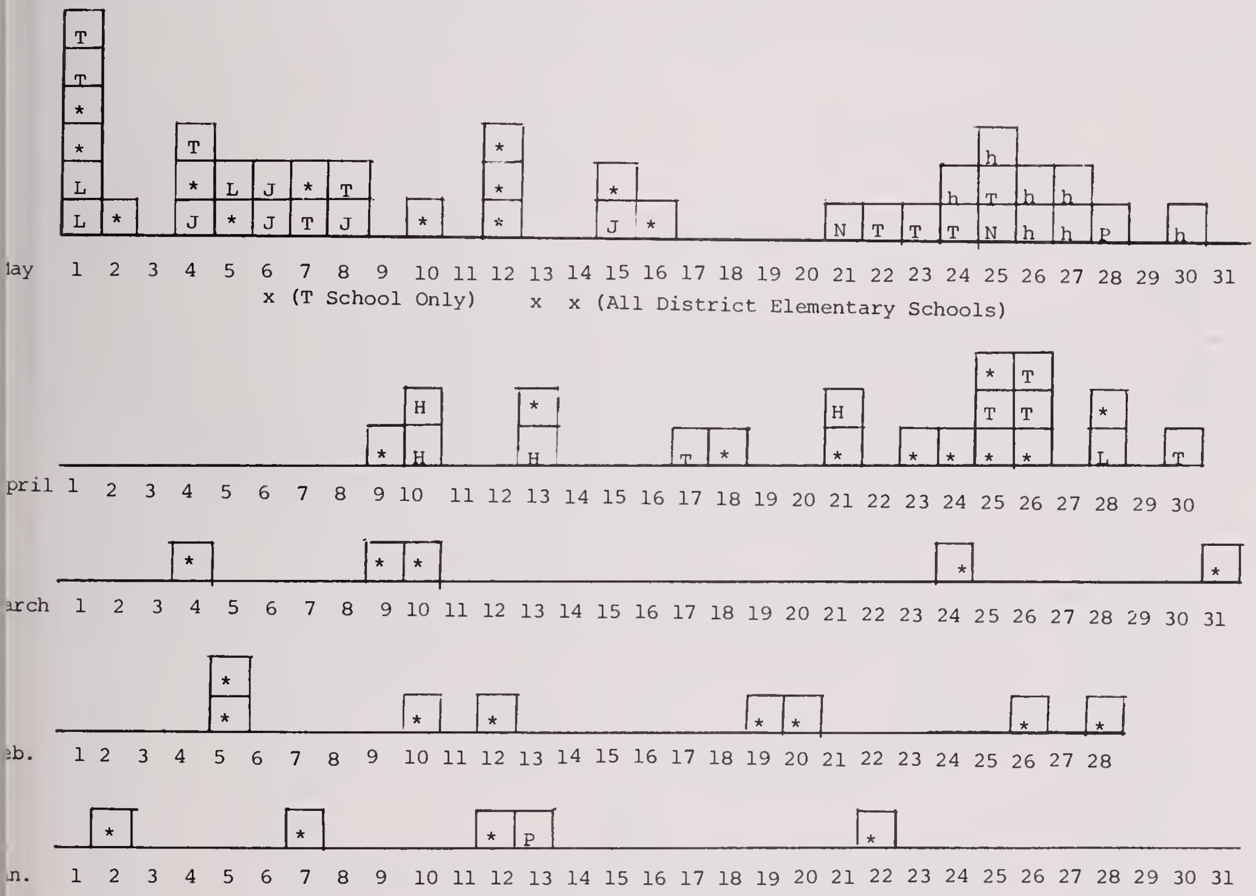

Fig. 2

jection to the vaccination and three had parents io were positive their child had received measles ccine. (They had actually received rubella vac- ie.)

Elementary School J
Total Enrolled 794
Grade 2 5
Grade 3 1
Total Cases 6

Of the six cases, three children had been vaccinated when under 1 year of age, one at 12 months, and two were unvaccinated.

Elementary School L
Total Enrollment 738
Total Cases 4
One case in each of the four grades.

Of the four cases, two children were vaccinated when over 1 year of age and two were unvaccinated.

Junior High School
Total Enrollment 1,532
Total Cases 7
All in grades 8

All eight children were unvaccinated. One child had a rise in titer from 1:8 to 1:64 in paired sera obtained 2 weeks apart.

High School
Total Enrollment 3,414
Total Cases 4

Of these four cases, two children possibly had inactivated vaccine, and two had questionable histories of vaccination. Two children had a rise in measles titer from 1:8 to 1:64.

Nursery School
Total Enrollment 60
Total Cases 2

Of these two 4-year-old cases, one child was vaccinated at 1 year of age and the other was unvaccinated.

Preschool in Community—Only two cases were reported in preschool children who did not attend a nursery school: a 3-year-old with onset on Jan. 13, 1975 and vaccination at 1-year of age with MMR, and a 4-year-old with onset May 28, 1975 and vaccination at age 3 years of age.

State law requires measles immunization for school attendance. A parent's statement is satisfactory evidence of compliance. Epidemiologic investigation of this outbreak demonstrates quite vividly that parent's knowledge of their children's immunization is not a very reliable source of information and that there is still great confusion about measles and rubella vaccines.

Control measures included calls to parents and doctors' offices to obtain vaccination histories and to insure that siblings and other close contacts of cases had vaccine or immune serum globulin; notices to parents of classroom contacts; and measles immunization clinics in the school district's 19 elementary schools, including the three elementary schools in which cases of measles occurred. (Since most children receive immunizations as part of their total health care, immunization programs are not a routine activity of any school health program in St. Louis County.)

An immunization audit was performed at the nursery school. Parents of inadequately immunized children were notified and those children who were determined to be susceptible were excluded until immunization was received. No further cases w reported from the nursery school. Approximat three weeks following the immunization clinic the elementary schools, four cases of measles curred in School T. Three of these children w unvaccinated, one because of the parent's religi objections to immunization and two because t parents were positive their children had recei measles vaccine.

The fact that seven cases of measles occurr in the junior high school suggests that a sch immunization clinic there might have been an i portant preventive measure. However, the o vaccine available through the Vaccination Assi ance Program is combined measles-rubella vacci The contraindications to providing the double an gen vaccine to postpubertal female junior hi school students would clearly have diluted su control activity. Also, most of these parents thoug that their children had had measles disease a probably would not have signed the consent for for their children to participate in such a clinic.

A possible source case of this outbreak was 3-year-old boy who became ill on Jan. 3, 1975 wi bronchitis. He was taken to his pediatrician's offi in an adjacent county where measles was prev lent and was thought to be exposed to measles the doctor's office. He became ill ten days lat with cough, coryza and a fever of 103 F, follow

TABLE 4

SCHEDULE FOR ACTIVE IMMUNIZATION OF NORMAL INFANTS AND CHILDREN AS RECOMMENDATIONED BY THE COMMITTEE O INFECTIOUS DISEASES OF THE AMERICAN ACADEMY OF PEDIATRICS

2 mo.	DTP[1]	TOPV[2]
4 mo.	DTP	TOPV
6 mo.	DTP	TOPV
1 yr.	Measles[3]	Tuberculin test
	Rubella[3]	Mumps[3]
1½ yr.	DTP	TOPV
4-6 yr.	DTP	TOPV
14-16 yr.	Td[5] and thereafter every 10 years	

1. DTP—diphtheria and tetanus toxoids combined with pertus vaccine.

2. TOPV—trivalent oral poliovirus vaccine. This recommendati is suitable for breast-fed as well as bottle-fed infants.

3. May be given at 1 year as measles-rubella or measles-mump rubella combined vaccines.

4. Frequency of repeated tuberculin tests depends on risk of e posure of the child and on the prevalence of tuberculosis in the po ulation group. The initial test should be at the time of, or prece ing, the measles immunization.

5. Td—combined tetanus and diphtheria toxoids (adult type) f those more than six years of age in contrast to diphtheria and tetan (DT) which contains a larger amount of diphtheria antigen. Tetan toxoid at time of injury: For clean, minor wounds, no booster do is needed by a fully immunized child unless more than ten yea have elapsed since the last dose. For contaminated wounds, a boos er dose should be given if more than five years have elapsed sin the last dose.

a rash which lasted six days. Koplik spots were ted. This child had received MMR vaccine at year of age. Although there is an interval of two onths between this case and other reported cases, is highly likely that a number of unreported ses occurred during this time.

No further cases were reported after the close school at the end of May.

MMARY

Although the goal of total measles eradication may not be realistic, it should be the goal of all in the health professions who serve children to see that measles vaccine as well as other immunizing agents (oral polio vaccine, diphtheria, tetanus toxoids, pertussis vaccine and rubella vaccine) are made available to every child and administered at the optimum age.

Table 4 is the Schedule for Active Immunization of Normal Infants and Children recommended by the American Academy of Pediatrics.

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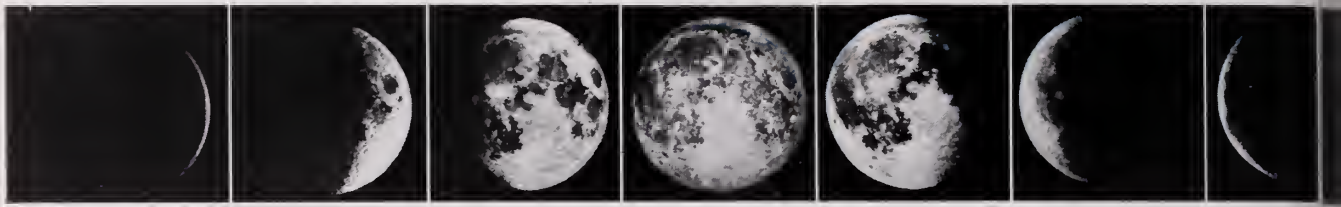
hite tablet contains 0.08 mg mestranol Each blue tablet contains 2.0 mg norethindrone and 0.08 mg mestranol.

†Serious as well as minor conditions have been reported following the use of oral contraceptives. These conditions include thromboembolic disease The physician should remain alert to the earliest manifestations of any symptoms of serious disease and discontinue oral contraceptive therapy when appropriate The physician should be fully aware of the complete Prescribing Information for this product.

See prescribing information on following page.

OJ 622-5

In sequence...



Ortho-Novum SQ Tablets

TRADEMARK

Description: ORTHO-NOVUM SO Tablets provide a sequential oral contraceptive regimen consisting of white tablets containing only mestranol 0 08 mg. and blue tablets containing both mestranol 0 08 mg and norethindrone 2 0 mg
Action: Gonadotrophin suppression
Special note: Oral contraceptives have been marketed in the United States since 1960. Reported pregnancy rates vary from product to product The effectiveness of the sequential products appears to be somewhat lower than that of the combination products Both types provide almost completely effective contraception

An increased risk of thromboembolic disease associated with the use of hormonal contraceptives has now been shown in studies conducted in both Great Britain and the United States Other risks, such as those of elevated blood pressure and reduced tolerance to carbohydrates, have been reported and appropriate tests should be conducted to monitor these during oral contraceptive therapy Liver disease has also been reported, and the physician should be alert to its earliest manifestations

Long-term administration of both natural and synthetic estrogens in subprimate animal species in multiples of the human dose increases the frequency for some animal carcinomas These data cannot be transposed directly to man The possible carcinogenicity due to the estrogens can neither be affirmed nor refuted at this time Close clinical surveillance of all women taking oral contraceptives must be continued
Indication: Contraception
Contraindications: 1 Thrombophlebitis, thromboembolic disorders, cerebral vascular disease, or a past history of these conditions 2 Markedly impaired liver function 3 Known or suspected carcinoma of the breast. 4 Known or suspected estrogen-dependent neoplasia 5 Undiagnosed abnormal genital bleeding 6 Known or suspected pregnancy
Warnings: 1 The physician should be alert to the earliest manifestations of thrombotic and thromboembolic disorders, thrombophlebitis, cerebrovascular disorders including hemorrhage, pulmonary embolism and retinal thrombosis Should any of these occur or be suspected, the drug should be discontinued immediately

Retrospective studies of morbidity and mortality in Great Britain and studies of morbidity in the United States have shown a statistically significant association between thrombophlebitis, pulmonary embolism and cerebral vascular disease, occlusive or hemorrhagic, and the use of oral contraceptives There have been three principal studies in Great Britain[1-3] leading to these conclusions and three in this country [4-7] The estimate of the relative risk of thromboembolism in the study by Vessey and Doll[3] was about sevenfold, while the United States studies found relative risks of 4 4 to 11, meaning that the users are several times as likely to undergo thromboembolic disease without evident cause as non-users

In May, 1974, the Royal College of General Practitioners in England[8] issued an interim report of its continuing large-scale prospective study comparing a user group to a non-user group. This study in its interim analysis states, A statistically significant higher rate of reporting of cerebrovascular accidents in Takers is evident, but the numbers are too small to justify an estimation of the degree of risk The study also reported a higher incidence of superficial and deep vein thrombosis in users as compared to non-users The risk of superficial and deep vein thrombosis was reported to be lower in women using 50 mcg estrogen preparations

The Sartwell study[4] indicated that the risk did not persist after discontinuation of administration. Both the Sartwell and the Royal College studies indicated that the degree of risk was not associated with duration of treatment

In a collaborative American study[5,6] of cerebrovascular disorders in women with and without predisposing causes, it was estimated that the relative risk of thrombotic stroke was 4 1 to 9.5 times greater in users than in non-users A comparable estimate for hemorrhagic stroke was 2 0

None of the American studies was designed to evaluate a difference between products. However, the Sartwell study[4] suggested that there might be an increased risk of thromboembolic disease in users of sequential products.

Other retrospective studies[9,10] have reported an increased risk of post-surgery thromboembolic complications in oral contraceptive users It has been recommended that therapy be discontinued at least one month prior to elective surgery
2 Discontinue oral contraceptive medication if there is: gradual or sudden partial or complete loss of vision; proptosis or diplopia, onset or aggravation of migraine or development of headache of a new pattern which is recurrent, persistent or severe, papilledema, or any evidence of retinal vascular lesions
3 Fetal abnormalities have been reported to occur in the offspring of women who have taken progestogens and/or estrogens during pregnancy [11,12] The safety of ORTHO-NOVUM SO in pregnancy has not been demonstrated Pregnancy should be ruled out before initiating or continuing the contraceptive regimen Pregnancy should always be considered if withdrawal bleeding does not occur
4 A small fraction of the hormonal agents in oral contraceptives has been identified in the milk of mothers receiving these drugs The long-range effect to the nursing infant cannot be determined at this time
5 Hepatic lesions (adenomas, hepatomas, hamartomas, regenerating nodules, etc.), occasionally fatal, have been reported in women on oral contraceptives Such lesions may present as an abdominal mass or with the signs and symptoms of an acute abdomen. These lesions should be considered if the patient has abdominal pain or evidence of intra-abdominal bleeding This has been reported in short-term as well as long-term users of oral contraceptives.

Precautions: 1 A thorough history and physical examination should be performed bef
ing oral contraceptives and periodically during their administration and should include s
ence to breasts and pelvic organs, including Papanicolaou smear since estrogens have
to produce tumors, some of them malignant, in five species of subprimate animals 2 En
possibly liver function tests may be affected by treatment with ORTHO-NOVUM SQ
such tests are abnormal in a patient taking ORTHO-NOVUM SO, it is recommended t
repeated after the drug has been withdrawn for two months 3 Under the influence
progestogen preparations, pre-existing uterine fibromyomata may increase in size 4 Be
agents may cause some degree of fluid retention, conditions which might be influenced b
such as epilepsy, migraine, asthma, cardiac or renal dysfunction, require careful obser
breakthrough bleeding, and in all cases of irregular bleeding per vaginam, nonfuncti
should be borne in mind In undiagnosed bleeding per vaginam, adequate diagnostic m
indicated 6 Patients with a history of psychic depression should be carefully observed a
discontinued if the depression recurs to a serious degree 7 Any possible influence o
ORTHO-NOVUM SO therapy on pituitary, ovarian, adrenal, hepatic or uterine function av
study 8 A decrease in glucose tolerance has been observed in a significant percentage
on oral contraceptives The mechanism of this decrease is obscure. For this reason, diabe
should be carefully observed while receiving ORTHO-NOVUM SO therapy 9. The age of
constitutes no absolute limiting factor, although treatment with ORTHO-NOVUM SQ ma
onset of the climacteric 10 The pathologist should be advised of ORTHO-NOVUM SQ th
relevant specimens are submitted 11. Susceptible women may experience an increa
pressure following administration of contraceptive steroids 12 Cholestatic jaundice
reported in users of oral contraceptives If this occurs, ORTHO-NOVUM SO should be d
This condition is more likely to occur in patients who have experienced cholestatic jaunc
nancy Patients with a history of cholestatic jaundice of pregnancy should be carefully ob
ing ORTHO-NOVUM SQ therapy

Adverse reactions observed in patients receiving oral contraceptives: A statistically
association has been demonstrated between use of oral contraceptives and the follow
adverse reactions thrombophlebitis, pulmonary embolism, cerebral thrombosis and h
gallbladder disease

Although available evidence is suggestive of an association, such a relationship has b
confirmed nor refuted for the following serious adverse reactions: neuro-ocular lesions,
thrombosis and optic neuritis, hepatic lesions with or without intra-abdominal bleeding

The following adverse reactions are known to occur in patients receiving oral cont
nausea, vomiting, gastrointestinal symptoms (such as abdominal cramps and
breakthrough bleeding, spotting, change in menstrual flow, amenorrhea during and afte
edema, chloasma or melasma, which may persist, cholestatic jaundice, migraine, ras
mental depression, change in weight (increase or decrease), breast changes (tenderne
ment and secretion), changes in cervical erosion and cervical secretions, suppression
when given immediately post-partum, rise in blood pressure in susceptible individuals

Although the following adverse reactions have been reported in users of oral contrac
association has been neither confirmed nor refuted: anovulation post-treatment, which ten
more frequently in women with a history of menstrual disorders; premenstrual-like
changes in libido, changes in appetite; cystitis-like syndrome; headache; intolerance to
ses, nervousness, dizziness; fatigue; backache, hirsutism; loss of scalp hair; erythema
erythema nodosum, hemorrhagic eruptions; itching; vaginitis

The following laboratory results may be altered by the use of oral contraceptives hepat
increased sulfobromophthalein retention and other tests; coagulation tests—increase in p
Factors VII, VIII, IX and X; decrease in anti-thrombin III; increase in platelet aggregab
function—increase in PBI, and butanol-extractable protein-bound iodine and decrease in
values, metyrapone test; pregnanediol determination.

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Ortho Pharmaceutical Corporation
Raritan, New Jersey 08869

WASHINGTON

Members of the House Ways and Means Com- ttee's subcommittee on health have heard testi- ony from foreign physicians extremely critical the federalized national health insurance (NHI) stems in their native lands and from seven U.S. ysicians who urged lawmakers not to allow this untry to stumble down the same path.

All witnesses were selected by subcommittee publican minority members to counterpoise guments made by liberal witnesses produced ring the summer by Democrat colleagues.

The major theme of the American physicians s that federal interference should be kept to a nimum. Five of the seven physicians suggested at some form of catastrophic insurance might be neficial.

Clinton S. McGill, M.D., Portland, Ore., told the bcommittee that "freedom within the widest pos- le latitudes in the practice of medical care is an gredient absolutely essential to the success of y NHI program."

John Hamilton, M.D., Rochester, N.Y., urged nination of administrative red tape and pro- sed a catastrophic plan based on patients' ability pay.

Marvin N. Lymberis, M.D., Charlotte, N.C., also oke favorably of catastrophic coverage, warning t an omnibus bill might bankrupt the govern- nt and leave the present health system in a mbles.

ohn Burkhardt, M.D., Knoxville, Tenn., said NHI st be carefully planned, cannot be all encompass- ; and must not interfere with the doctor-patient ationship.

David Masland, M.D., Carlisle, Pa., warned of ossible paper work explosion if NHI is entered, ged use of private carriers rather than a federal eaucracy and noted that social factors have the gest impact on the health of the nation.

Brooker Masters, M.D., Freemont, Mich., said nation does not have the resources at present NHI. Rationing of services would be required, ulting in "medical care dictated by edicts in the leral Registry" which would lead to "chaos."

Donald Quinlan, M.D., Northfield, Ill., read a ongly-worded statement opposing any new federal program as "compulsory politicized medicine." He accused the Administration and Congress of the "great rip-off" of deficit financing.

The domestic panel was questioned by subcommittee chairman Dan Rostenkowski (D-Ill.) and Reps. John Duncan (R-Tenn.), James Martin (R-N.C.) and Philip Crane (R-Ill.). They praised the panel members for their testimony.

Asked by Rep. Charles Vanik (D-Ohio) to give a show of hands on how many would support a catastrophic plan, six of the witnesses raised their hands, but none did when he asked for their sentiments on catastrophic health insurance operated by Social Security. Vanik contended that the public is pushing Congress on NHI, asserting that the lawmakers are not the innovators.

The foreign panel consisted of two British physicians, a British medical writer, a former Swedish physician and a Canadian physician—Max Gammon, M.D., London; Reginald S. Murley, M.D., London; Anthony Jejeune, Middlesex, England, medical writer; Sigmund J. Lofstead, M.D., Chicago; and Bette Stephenson, M.D., Toronto.

As a group, they urged Congress not to permit governmental control of medicine in this country.

The British witnesses painted a black picture of the situation in England. Dr. Murley said almost all physicians in England are totally opposed to the policies of the government and predicted a "massive confrontation" soon.

Dr. Lofstead, who had practiced in Sweden, said health care has become regimented and politicized in that country. Most people in the U.S., he said, have financial access to the best and most sophisticated health care in the world.

Dr. Stephenson was less critical of the Canadian program, but said any NHI program should involve as little distortion of the present U.S. system as possible. She said fee-for-service is the most efficient and fairest method of payment.

Dr. Gammon said it is imperative that the U.S. resist the socialization of medicine "for the good of the rest of the free world." He said that "if you believe that the state is better able to control the affairs of individuals than they are, then the prospects of freedom for the rest of the world are very dim."

* * *

Despite continued optimism on the part of some members of House Ways and Means that a NHI bill can be drafted this year, Capitol Hill oddsmakers are still betting it can't be done.

Besides the scarcity of time—at least 400 witnesses will be heard by Ways and Means alone—the jurisdictional battle between Ways and Means and House Commerce is far from solved.

Senior staffers of both committees are being quoted as saying "effective NHI cannot come out of a Congress with the present messed-up jurisdiction" and "it simply can't be done in two committees."

Nonetheless, the chance always remains that House leadership under the pressures of an election year could knock heads together until a hurried bill was produced.

* * *

The Administration has opposed a domestic draft of young physicians for service in shortage areas and urged Congress to phase-out capitation grant support for the nation's medical schools.

Testifying before the Senate Health Subcommittee as it opened hearings on health manpower legislation, Theodore Cooper, M.D., Assistant Secretary for Health at the Health, Education and Welfare Department, said:

"We are seriously concerned that the general taxpayer—by means of federal taxes—will be called upon to subsidize in perpetuity the professional training of physicians, dentists and other well-paid health professionals."

Dr. Cooper told the Subcommittee, headed by Sen. Edward Kennedy (D-Mass.), that legislation backed by Kennedy that calls for $5 billion in aid over the next five years is "unnecessary to elicit adequate numbers of students for schools which today accommodate only one out of every two to three qualified applicants."

The Administration "strongly opposes" the compulsory service feature in the legislation requiring all graduates to serve in shortage areas. "This requirement could mean that in the very near future the federal government would have the responsibility for placing and monitoring the professional activities of thousands of individuals in the health s
tem." Dr. Cooper proposed instead to strength
the National Health Service Corps scholarship p
gram.

The American Medical Association declared "
continuing frustrations of the public and the e
nomic limitations on resorting to the courts for
remedial action must be viewed seriously by t
subcommittee and this Congress."

Edgar T. Beddingfield, M.D., Vice-Chairman
the AMA's Council on Legislation, referring
HEW's index for figuring physicians' fees un
Medicare, said "If the administrative process is
be unbridled and is to be permitted to disreg
the rights of individuals and arbitrarily to establ
essential factors without adequate compliance w
the law, then a discussion of the provisions enact
by Congress in essence becomes moot."

Charging "abuse of the regulatory process"
HEW, Dr. Beddingfield said effects of the econo
ic index will be to lower reimbursement rates
many procedures below the rates recognized
the program in fiscal 1975."

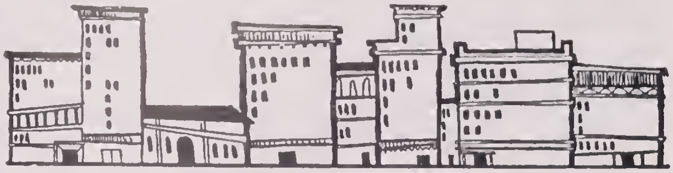
The 1972 Social Security Amendments L
which set Medicare payment controls at the 7
percentile with future adjustments tied to an in
determined by HEW is "clearly discriminator
the AMA witness said. "We are not aware of a
segment of society against which similar contr
are imposed by Congress." Upshot of such c
trols, he warned, "will be to shift an increasing
nancial burden on the beneficiaries."

Dr. Beddingfield urged acceptance of the AM
19 amendments to the Professional Standards
view Organization (PSRO) program and postpo
ment of the Jan. 1, 1976, deadline for professio
associations to form PSROs.

The Assistant Secretary also attacked provisi
imposing a federal regulatory scheme to control
numbers and allocation of training positions
graduate medical education and to institute a
tional licensure system for physicians and dentis
"We feel that there is little basis for initiating t
far-reaching regulatory mechanism at this tim
Dr. Cooper said.

By 1985 the U.S. will have from 207 to 217 p
sicians per 100,000 population, he testified, plac
this nation "near the top of all the industrialized
tions in terms of overall physician supply."

rom the ledical Schools



T. LOUIS UNIVERSITY

A total of 155 new freshmen students enrolled in udies at the St. Louis University School of Med- ine participated in an orientation program held at e School on August 29. Women freshmen num- red 23. *Dr. William Stoneman, III*, associate dean, hool of Medicine, was among administrators who ldressed the students.

Fourteen physician assistants received certificates signating completion of their two years of study ceremonies held on August 22, at which *L. M. etmer* delivered the keynote address on "Pioneers the Present." He is assistant director and secre- ry, Joint Review Committee on Educational Pro- ams for the Assistant to the Primary Care Phy- cian, American Medical Association.

Dr. Frances Horvath, program director of the St. uis Inter-Institutional Physicians Assistant Pro- am at the School of Nursing and Allied Health ofessions, presented the certificates. Nine of this ar's graduates were from Missouri. This is the ogram's fifth year. A total of nine of the graduates ere former military corpsmen.

Three awards have been received by the School Medicine and St. Louis University Hospitals hich will support research and teaching programs.

The School of Medicine was the recipient of a 03,374 multidisciplinary heart and vascular dis- ses training grant awarded by the National Heart d Lung Institute for a five-year period which gan on July 1. Purpose of the program is to train edical and Ph.D. graduates in the biomedical sci- ces in nutrition, metabolism and basic physiology it applies to the cardiovascular system. The pro- am director is *Dr. Robert E. Olson*, professor and airman of the Department of Biochemistry and ofessor of medicine. The program is a joint effort tween the Departments of Biochemistry and ysiology. *Dr. Alexander R. Lind,* whose depart- ent will be affiliated with the program, is professor d chairman of the Department of Physiology.

A $615,278 contract has been awarded by the ational Cancer Institute for the establishment of a ain Tumor Study Group program to be head- artered at the St. Louis University Hospitals rough the joint efforts of the School of Medicine, urosurgeons on the staff of St. Luke's Hospital who are members of the faculty at the Missouri University School of Medicine and radiation therapists at Washington University School of Medicine. The contract recently became effective for a five-year period.

Dr. William Stoneman, III, associate dean, St. Louis University School of Medicine, addresses medical freshmen at orientation program marking start of academic year.

Dr. Kenneth R. Smith, Jr., professor of surgery and chairman of the Section of Neurosurgery at the School of Medicine, is director of the new program. *Dr. George E. Roulhac,* clinical professor of neurosurgery, University of Missouri, and chief of neurosurgery at St. Luke's Hospital, is co-director.

The St. Louis University Medical Center has received a $129,197 award from the National Cancer Institute for the establishment of an Exploratory Study for a St. Louis University Cancer Center.

Dr. George E. Thoma, vice-president for the Medical Center, says the total thrust of the new program will be to determine whether a Multidisciplinary Specialized Cancer Center can be developed at St. Louis University and what role that Center could play in a comprehensive cancer center for the state of Missouri. He said that it is hoped that the development of the Center can be completed in about 18 months.

The Medical Center receives $2.5 million a year in federal funds for support of cancer projects. The principal objective of the new study is to plan an integrated program encompassing existing projects and also to develop new ones.

UNIVERSITY OF MISSOURI-KANSAS CITY

The strength of the physiology faculty continues to increase with the recent acquisition of three new physiologists. *Drs. Judith Hemberger, Garth Resch* and *George Temple* have joined the UMKC Arts and Science Biology Department with a joint appointment in the School of Medicine. This brings to a total of nine the number of physiologists offering courses to the medical students at all levels of the six year program.

In addition, a program of visiting professors in physiology has brought several distinguished scientists to the UMKC campus to teach both in Arts and Sciences and Medical School Physiology courses. In the past three years, seven new physiologists have joined the UMKC campus. All of the basic scientists hold joint appointments with the School of Medicine and are teaching medical students.

The 1975 revised edition of the Curriculum Book has just been printed and is being distributed among the students and faculty. The book has been put together following a number of meetings by the clinical faculty in different medical specialties who have defined the concepts, facts and skills needed by a graduating medical student. Many of the clinical faculty members are practicing physicians in the Kansas City Metropolitan area who have contributed substantial time to the planning of the Book.

Sixty-two Year-2 students have recently completed their summer preceptorships with physicians all over Missouri. Evaluations of the students reflect a great enthusiasm by the physicians who have had these preceptees. Many of the students live with the physicians and participate in social as well as professional activities. The students have reported increasing enthusiasm each year following this Year-2 preceptorship.

The Medical School library has received $77,360 for continuation for one year of a federal grant for Clinical Medical Librarians. There will be four Clinical Medical Librarians funded who serve on each of the four Docent Units, as well as two new Clinical Medical Librarians to be added who will serve Surgery, Obstetrics-Gynecology and Emergency Medicine units. These librarians have made rounds with physicians on the patient care units, done literature searches on a current basis for patients on the units and have provided reprints of articles concerning the disease conditions seen, frequently on the same day the rounds have been made. House staff physicians as well as the Docents have found these Medical Librarians to be a very valuable addition to the patient care units.

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Support—Sheer & Surgical Elastic Pneumatic

From tired legs to severe circulatory disorders

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WASHINGTON UNIVERSITY

The School of Medicine has received a three-year, $184,966 grant from the National Institute of Neurologic Diseases and Stroke to evaluate childhood bacterial meningitis.

Ralph D. Feigin, M.D., professor of pediatrics, is chairman of the Division of Infectious Diseases and principal investigator in the study.

"Even with early and carefully controlled antibiotic treatment provided intravenously, today (1975) the death rate still reaches 5% to 8% and 40% of the survivors have permanent neurologic handicaps," he said.

Sixty-five percent of bacterial meningitis in children between three months and 15 years old is due to bacterial Hemophilus influenzae, type b. About one in every 1,000 children born each year will be afflicted by this bacteria by the age of five.

These studies are designed to assess methods of therapy and to evaluate the long-term effects of bacterial meningitis. Researchers also will study the pathogenesis of the disease in an attempt to find reason for the increased incidence of it.

Co-investigators are *Philip R. Dodge*, M.D., chairman and professor of the Department of Pediatrics; *Penelope G. Shackelford*, M.D., assistant professor of pediatrics; and *Helen Palkes*, assistant professor of psychology in pediatrics.

The National Institutes of Health have awarded a three-year grant of $167,298 to Washington University School of Medicine for support of research in fungus disease.

Gerald Medoff, M.D., associate professor of medicine and assistant professor of microbiology and Chief of the Division of Infectious Diseases at the School, is the principal investigator of the grant.

The research funded by this grant deals primarily with finding better ways to diagnose and treat histoplasmosis, a fungus infection which resembles tuberculosis and is common in the Middle West.

Continuing Education Coming Events

Oct. 15	**Seminar in Noninvasive Cardiology: Electrocardiography** Depts. of Medicine & Radiology, St. Luke's Hospital and Washington U. Continuing Medical Education St. Luke's Hospital, St. Louis
Oct. 21-22	**Symposium: Medicine and Religion—Ethical Issues in Modern Health Care** Division of Continuing Education K.U. Medical Center, Kansas City, Kan.
Oct. 23	**Special All-Day Program: Echocardiography of Myocardial Function** Depts. of Medicine & Radiology, St. Luke's Hospital and Washington U. Continuing Medical Education St. Luke's Hospital, St. Louis
Oct. 23-25	**53rd Annual Fall Clinical Conference** Kansas City Southwest Clinical Society Crown Center Hotel, Kansas City
Oct. 23-25	**Oncology—Current Concepts and Future Prospects** Division of Hematology and Oncology and Continuing Medical Education Washington U. School of Medicine, St. Louis
Oct. 29	**Seminar in Noninvasive Cardiology: Stress Testing** Depts. of Medicine & Radiology, St. Luke's Hospital and Washington U. Continuing Medical Education St. Luke's Hospital, St. Louis
Nov. 5-7	**Clinical Advances in Pediatrics** Postgraduate Education, Menorah Medical Center The Children's Mercy Hospital, Kansas City
Nov. 5 & 12	**Seminar in Noninvasive Cardiology: Vectorcardiography** Depts. of Medicine & Radiology, St. Luke's Hospital and Washington U. Continuing Medical Education St. Luke's Hospital, St. Louis
Nov. 10	**City-Wide Radiology Conference: Newer Approaches in Ultrasound** Mallinckrodt Institute of Radiology Washington U. School of Medicine, St. Louis
Nov. 10-13	**Symposium: Internal Medicine** Division of Continuing Education K.U. Medical Center, Kansas City, Kan.
Nov. 6-9	**27th Annual Scientific Assembly** Missouri Academy of Family Physicians Lodge of the Four Seasons, Lake Ozark

(Continued on page 616)

FALL PANEL DISCUSSION
"Thrombophlebitis"

THE ST. LOUIS SURGICAL SOCIETY

Marion DeWeese, M.D.
Ann Arbor, Michigan
"Guest Moderator"

Arthur Auer, M.D.
St. Louis, Missouri

Tom Covey, M.D.
St. Louis, Missouri

Edward Coleman, M.D.
St. Louis, Missouri

James Debnam, M.D.
St. Louis, Missouri

TUESDAY, NOVEMBER 4, 1975
5:30 P.M.

ST. LOUIS MEDICAL
SOCIETY AUDITORIUM

All Members of the
Profession Invited

IMPORTANT INFORMATION: *This is a Schedule V substance by Federal law; diphenoxylate HCl is chemically related to meperidine. In case of overdosage or individual hypersensitivity, reactions similar to those after meperidine or morphine overdosage may occur; treatment is similar to that for meperidine or morphine intoxication (prolonged and careful monitoring). Respiratory depression may recur in spite of an initial response to Nalline® (nalorphine HCl) or Narcan® (naloxone HCl) or may be evidenced as late as 30 hours after ingestion. LOMOTIL IS NOT AN INNOCUOUS DRUG AND DOSAGE RECOMMENDATIONS SHOULD BE STRICTLY ADHERED TO, ESPECIALLY IN CHILDREN. THIS MEDICATION SHOULD BE KEPT OUT OF REACH OF CHILDREN.*

Indications: Lomotil is effective as adjunctive therapy in the management of diarrhea.

Contraindications: In children less than 2 years, due to the decreased safety margin in younger age groups, and in patients who are jaundiced or hypersensitive to diphenoxylate HCl or atropine.

Warnings: Use with special caution in young children, because of variable response, and with extreme caution in patients with cirrhosis and other advanced hepatic disease or abnormal liver function tests, because of possible hepatic coma. Diphenoxylate HCl may potentiate the action of barbiturates, tranquilizers and alcohol. In theory, the concurrent use with monoamine oxidase inhibitors could precipitate hypertensive crisis. In severe dehydration or electrolyte imbalance, withhold Lomotil until corrective therapy has been initiated.

Usage in pregnancy: Weigh the potential benefits against possible risks before using during pregnancy, lactation or in women of childbearing age. Diphenoxylate HCl and atropine are secreted in the breast milk of nursing mothers.

Precautions: Addiction (dependency) to diphenoxylate HCl is theoretically possible at high dosage. Do not exceed recommended dosages. Administer with caution to patients receiving addicting drugs or known to be addiction prone or having a history of drug abuse. The subtherapeutic amount of atropine is added to discourage deliberate overdosage; strictly observe contraindications, warnings and precautions for atropine; use with caution in children since signs of atropinism may occur even with the recommended dosage. Use with care in patients with acute ulcerative colitis and discontinue use if abdominal distention or other symptoms develop.

Adverse reactions: Atropine effects include dryness of skin and mucous membranes, flushing, hyperthermia, tachycardia and urinary retention. Other side effects with Lomotil include nausea, sedation, vomiting, swelling of the gums, abdominal discomfort, respiratory depression, numbness of the extremities, headache, dizziness, depression, malaise, drowsiness, coma, lethargy, anorexia, restlessness, euphoria, pruritus, angioneurotic edema, giant urticaria, paralytic ileus, and toxic megacolon.

Dosage and administration: ***Lomotil is contraindicated in children less than 2 years old.*** Use only Lomotil liquid for children 2 to 12 years old. For ages 2 to 5 years, 4 ml. (2 mg.) t.i.d.; 5 to 8 years, 4 ml. (2 mg.) q.i.d.; 8 to 12 years, 4 ml. (2 mg.) 5 times daily; adults, two tablets (5 mg.) t.i.d. to two tablets (5 mg.) q.i.d. or two regular teaspoonfuls (10 ml., 5 mg.) q.i.d. Maintenance dosage may be as low as one fourth of the initial dosage. Make downward dosage adjustment as soon as initial symptoms are controlled.

Overdosage: Keep the medication out of the reach of children since accidental overdosage may cause severe, even fatal, respiratory depression. Signs of overdosage include flushing, hyperthermia, tachycardia, lethargy or coma, hypotonic reflexes, nystagmus, pinpoint pupils and respiratory depression which may occur 12 to 30 hours after overdose. Evacuate stomach by lavage, establish a patent airway and, when necessary, assist respiration mechanically. A narcotic antagonist may be used in severe respiratory depression. Observation should extend over at least 48 hours.

Dosage forms: Tablets, 2.5 mg. of diphenoxylate HCl with 0.025 mg. of atropine sulfate. Liquid, 2.5 mg. of diphenoxylate HCl and 0.025 mg. of atropine sulfate per 5 ml. A plastic dropper calibrated in increments of ½ ml. (total capacity, 2 ml.) accompanies each 2-oz. bottle of Lomotil liquid.

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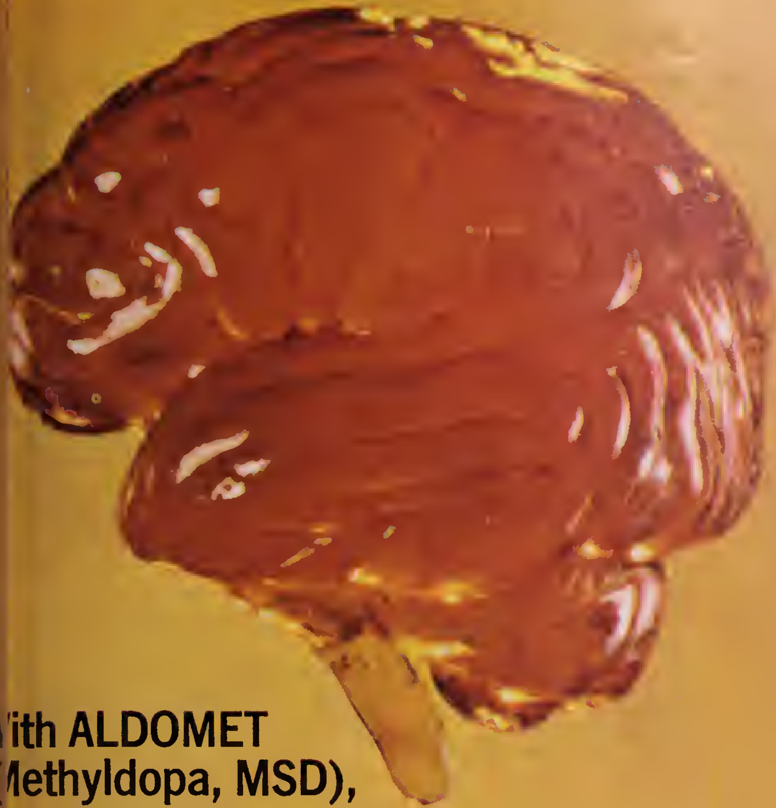

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molytic anemia, and liver disorders may occur with
thyldopa therapy. The rare occurrences of hemolytic anemia
liver disorders could lead to potentially fatal complica-
ns unless properly recognized and managed. For more
tails see the brief summary of prescribing information.

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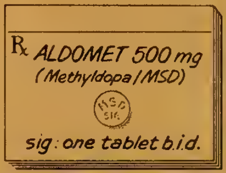

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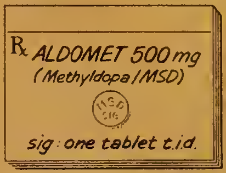

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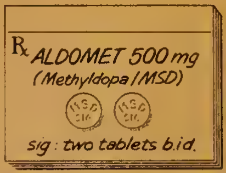

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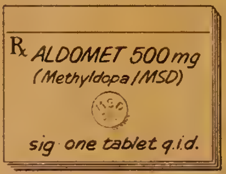

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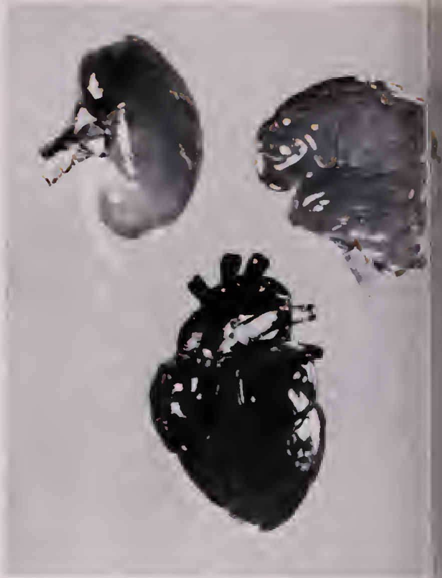

Contraindications: Active hepatic disease, such as acute hepatitis and active cirrhosis; if previous methyldopa therapy has been associated with liver disorders (see Warnings); hypersensitivity.

Warnings: It is important to recognize that a positive Coombs test, hemolytic anemia, and liver disorders may occur with methyldopa therapy. The rare occurrences of hemolytic anemia or liver disorders could lead to potentially fatal complications unless properly recognized and managed. Read this section carefully to understand these reactions.

With prolonged methyldopa therapy, 10% to 20% of patients develop a positive direct Coombs test, usually between 6 and 12 months of therapy Lowest incidence is at daily dosage of 1 g or less. This on rare occasions may be associated with hemolytic anemia, which could lead to potentially fatal complications. One cannot predict which patients with a positive direct Coombs test may develop hemolytic anemia. Prior existence or development of a positive direct Coombs test is not in itself a contraindication to use of methyldopa If a positive Coombs test develops during methyldopa therapy, determine whether hemolytic anemia exists and whether the positive Coombs test may be a problem. For example, in addition to a positive direct Coombs test there is less often a positive indirect Coombs test which may interfere with cross matching of blood

At the start of methyldopa therapy, it is desirable to do a blood count (hematocrit, hemoglobin, or red cell count) for a baseline or to establish whether there is anemia. Periodic blood counts should be done during therapy to detect hemolytic anemia It may be useful to do a direct Coombs test before therapy and at 6 and 12 months after the start of therapy If Coombs-positive hemolytic anemia occurs, the cause may be methyldopa and the drug should be discontinued Usually the anemia remits promptly. If not, corticosteroids may be given and other causes of anemia should be considered. If the hemolytic anemia is related to methyldopa, the drug should not be reinstituted When methyldopa causes Coombs positivity alone or with hemolytic anemia, the red cell is usually coated with gamma globulin of the IgG (gamma G) class only The positive Coombs test may not revert to normal until weeks to months after methyldopa is stopped.

Should the need for transfusion arise in a patient receiving methyldopa, both a direct and an indirect Coombs test should be performed on his blood In the absence of hemolytic anemia, usually only the direct Coombs test will be positive. A positive direct Coombs test alone will not interfere with typing or cross matching. If the indirect Coombs test is also positive, problems may arise in the major cross match and the assistance of a hematologist or transfusion expert will be needed.

Fever has occurred within first 3 weeks of therapy, sometimes with eosinophilia or abnormalities in liver function tests, such as serum alkaline phosphatase, serum transaminases (SGOT, SGPT), bilirubin, cephalin cholesterol flocculation, prothrombin time, and bromsulphalein retention. Jaundice, with or without fever, may occur, with onset usually in the first 2 to 3 months of therapy. In some patients the findings are consistent with those of cholestasis. Rarely fatal hepatic necrosis has been reported. These hepatic changes may represent hypersensitivity reactions; periodic determination of hepatic function should be done particularly during the first 6 to 12 weeks of therapy or whenever an unexplained fever occurs. If fever and abnormalities in liver function tests or jaundice appear, stop therapy with methyldopa If caused by methyldopa, the temperature and abnormalities in liver function characteristically have reverted to normal when the drug was discontinued Methyldopa should not be reinstituted in such patients.

Rarely, a reversible reduction of the white blood cell count with primary effect on granulocytes has been seen. Reversible thrombocytopenia has occurred rarely. When used with other antihypertensive drugs, potentiation of antihypertensive effect may occur. Patients should be followed carefully to detect side reaction or unusual manifestations of drug idiosyncrasy.

Use in Pregnancy: Use of any drug in women who are or may become pregnant requires that anticipated benefits be weighed against possible risks; possibility of fetal injury can not be excluded.

Precautions: Should be used with caution in patients with history of previous liver disease or dysfunction (see Warnings). May interfere with measurement of: uric acid by the phosphotungstate method, creatinine by the alkaline picrate method, and SGOT by colorimetric methods Since methyldopa causes fluorescence in urine samples at the same wavelengths as catecholamines, falsely high levels of urinary catecholamines may be reported This will interfere with the diagnosis of pheochromocytoma. It is important to recognize this phenomenon before a patient with a possible pheochromocytoma is subjected to surgery. Methyldopa is not recommended for patients with pheochromocytoma. Urine exposed to air after voiding may darken because of breakdown of methyldopa or its metabolites.

Stop drug if involuntary choreoathetotic mo
occur in patients with severe bilateral cereb
lar disease. Patients may require reduced
anesthetics; hypotension occurring durin
thesia usually can be controlled with vaso
Hypertension has recurred after dialysis in
on methyldopa because the drug is remove
procedure.

Adverse Reactions: *Central nervous*
Sedation, headache, asthenia or weakness,
early and transient; dizziness, lighthea
symptoms of cerebrovascular insuff
paresthesias, parkinsonism, Bell's palsy, inv
choreoathetotic movements; psychic distu
including nightmares and reversible mild ps
or depression.

Cardiovascular: Bradycardia, aggravation o
pectoris. Orthostatic hypotension (decrea
dosage). Edema (and weight gain) usually
by use of a diuretic. (Discontinue methy
edema progresses or signs of heart failure

Gastrointestinal: Nausea, vomiting, dis
constipation, flatus, diarrhea, mild dry
mouth, sore or "black" tongue, panc
sialadenitis.

Hepatic: Abnormal liver function tests,
liver disorders.

Hematologic: Positive Coombs test, he
anemia. Leukopenia, granulocytopenia,
bocytopenia.

Allergic: Drug-related fever, skin rash.

Other: Nasal stuffiness, rise in BUN, breast
ment, gynecomastia, lactation, impo
decreased libido, mild arthralgia, myalgia.

Note: Initial adult dosage should be lim
500 mg daily when given with antihypert
other than thiazides. Tolerance may occur,
between second and third month of thera
creased dosage or adding a thiazide fre
restores effective control. Patients with i
renal function may respond to smaller dose
cope in older patients may be related to in
sensitivity and advanced arteriosclerotic v
disease; this may be avoided by lower dose

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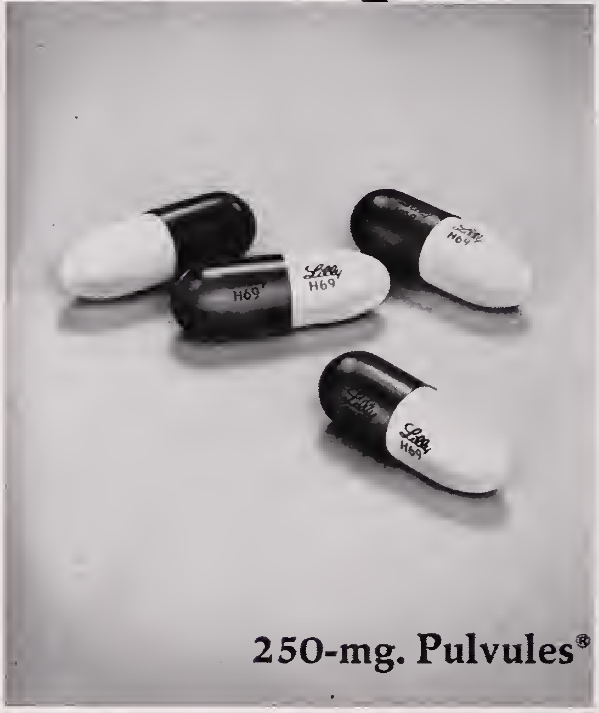

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ROBERT M. HERMAN, M.D., *Los Gatos, Calif. and*
JOHN F. SIMONDS, M.D., *Columbia*

ncidence of Conversion Symptoms in hildren Evaluated Psychiatrically

I THE PRACTICE of clinical child psychiatry,
rces of referral, such as schools, physicians and
ial agencies, are cued by certain behaviors and
nptoms that an emotional disorder might be
sent. Some symptoms, such as learning failure,
seen predominantly by one agency, such as the
ools. Physicians see a high percentage of pa-
nts with physical complaints that have an emo-
nal basis, e.g., conversion symptoms. On the
er hand, conversion symptoms in children are
t frequently reported by mental health clinics.

It is suspected that many children with conver-
n symptoms are being seen by primary care phy-
ians who are not referring these patients for
ntal health evaluations. One of the authors
ved jointly as a staff psychiatrist for a mental
alth center and as a child psychiatry consultant
the pediatric inpatient service at a large medical
ter. Psychiatric consultation to the pediatric in-
tient service provided the data base for compara-
e studies of the incidence of conversion symp-
ns among the referred pediatric inpatient popu-
ion with the incidence of conversion symptoms
n at the mental health center.

The studies of children with conversion reac-
ns or conversion hysteria do not consistently ap-
the same criteria for diagnosis. The criteria
forth in Rock's[1] article but based on Ziegler's[2]
dy for defining conversion reaction and conver-
n symptoms were used in evaluating the clinical
data presented in this paper. These criteria were as follows:

(1) The term "conversion reaction" should be used rather than conversion hysteria, which should be applied to adults only. To make the diagnosis of conversion reaction there should be:

(a) One relatively prominent somatic symptom (motor or sensory) with no apparent anatomic or physiologic basis.

(b) An onset or exacerbation with an emotionally significant event.

(c) A psychiatric examination which reveals that the symptoms are psychologically or emotionally derived.

This study compares the incidence of conversion symptoms among the referred pediatric inpatient population with the incidence of conversion symptoms seen at the mental health center. The research indicates that in most cases, patients with conversion symptoms were initially seen by the primary care physicians. Suggestions for the management of patients with conversion symptoms are included. Dr. Herman is in the private practice of Child Psychiatry and Dr. Simonds is Associate Professor of Psychiatry, University of Missouri School of Medicine.

TABLE 1

CHILD PSYCHIATRY CLINIC CASES

Case	*Age/Race/Sex*	*Symptoms*	*Associated Family Problems*	*Disposition*
#1	16/N/F	History of back pains, headaches, fainting spells; organic work-up negative; very dependent person.	Father unemployed several years and had back pains; mother overprotective; pains related to getting attention from mother and getting out of school.	Psychiatric hospitalization w milieu therapy and no medi tion. After discharge, took ov dose of aspirin and was admit to medical ward.
#2	10/W/F	Intermittent complaints of neck pains following car accident; abdominal pains before going to school; organic work-up negative.	Father depressed and suicidal. Mother overprotective; marital conflicts; favorite aunt and grandfather killed in car accident.	Outpatient psychiatric tr ment followed by hospitali tion on Adolescent Psychia Ward.
#3	11/W/F	Difficulty swallowing; organic work-up negative; past history of choking on ice cube at age 3.	Father authoritarian, mother phobic; death of close teenage friend due to cancer of lung one month prior to onset of symptoms.	Unknown
#4	11/W/M	Severe frontal headaches eight-months duration began six weeks after being hit on head; organic work-up negative.	Father autocratic, mother utilized as servant; family communication poor; headaches began at a time when father and older son were having frequent arguments.	Patient referred back to ho town medical clinic. Follow communication indicated t symptoms were no longer p ent.

(2) The term "conversion symptom" should be used if the criteria for conversion reaction cannot be met. The symptom is considered secondary to another syndrome or entity such as a personality disorder.

Method

During a 15-month period, the charts of patients seen at Mid-Missouri Mental Health Center children's outpatient clinic and the charts of patients who had received child psychiatry consultations at the University of Missouri Medical Center were individually reviewed by the authors. When somatic symptoms including pain without organic basis were found, the criteria recommended in Rock's[1] article were applied. Regarding pain syndromes as conversion symptoms was consistent with several reports in the literature.[3–5] No attempt was made to separate conversion symptoms from conversion reactions. The diagnosis of at least a conversion symptom and probably a conversion reaction was made in 15 patients by two child psychiatrists independently reviewing the case histories. Brief case descriptions of each patient (Tables 1 & 2) exemplify the kinds of presenting symptoms.

Results

The number of cases referred to the child psychiatry outpatient clinic during the 15-month period was 325. Since eight of these patients were referred after initially being seen by the child psychiatry consultant, the final total was 317.

Fig. 1 shows the age, sex and racial breakdown
patients referred to the child psychiatry clinic. T
patients lived in small Central Missouri towns.
the five patients with conversion symptoms in
6- to 12-year age group, two boys had been seen
the child psychiatry consultant and were refer
to the outpatient clinic for treatment. The in
dence of conversion symptoms for the differ
age groups was 0% under age 6; 3%, age 6 to
(1.8% if the two patients initially diagnosed d
ing consultation were excluded); .7%, age 13 to
The overall percentage of patients with convers
symptoms first seen by the outpatient clinic
1.3%.

Fig. 2 indicates the cases of conversion syn
toms diagnosed in patients seen initially for ch
psychiatry consultation. All of these children w
under the care of the pediatric inpatient servi
A total of 50 patients from rural towns in Miss
ri were evaluated during the same 15-month pe
od. Three patients (16.7%) in the six- to ten-y
age group were diagnosed as having conversi
symptoms while eight patients (28.6%) in the
to 16 age group were diagnosed with conversi
symptoms. The total number of 11 patients rep
sented 22% of the sample. Fig. 3 summarizes
totals for patients seen by both the child psych
try outpatient clinic and the child psychiatry c
sultant.

Fig. 4 is Rock's[1] summary of cases referred
the child psychiatrist at Tripler General Hospi
in Hawaii. Comparison with Fig. 3 shows that

TABLE 2

CHILD PSYCHIATRY CONSULTATIONS FOR PEDIATRIC INPATIENTS

ase	*Age/Race/Sex*	*Symptoms*	*Associated Family Problems*	*Disposition*
5	11/W/M	Abdominal pains for one year, hospitalized three times, organic work-up negative; personality profile indicated immature anxious child.	Father rigid, mother permissive, no agreed discipline; pains related to stressful situations at school and at home.	Two-and-one-half month psychiatric hospitalization, treatment involved milieu therapy and behavior modification marital counseling for parents. Follow-up report indicated no recurrence of symptoms.
6	12/W/M	Two-month history of generalized pains and weakness in legs; organic work-up negative; passive aggressive behavior with family members.	Youngest of six children. Parents were planning on adopting a seventh child and final approval for adoption came before onset of patient's symptoms.	Two-month psychiatric hospitalization, symptoms were associated with parent visits; gradually gave up symptoms without recurrence following discharge.
7	12/W/M	Shortness of breath, tightness in chest, pallor, jerking of body all observed during pediatric hospitalization; moderate anxiety.	One year previously had inhaled acid fumes and had trouble breathing; worried about brother's transfer to Vietnam.	Psychiatric hospitalization, symptoms ceased after first day with no recurrence.
8	13/W/M	Two-year history of blackout spells and seizures; organic work-up negative.	Symptoms became worse when father left the family; spells especially noticeable when child was threatened with punishment; during hospitalization, symptoms worse when father visited.	Unknown
9	15/W/M	Six-year history of chest pains aggravated by exercise and work, headaches associated with chest pains one-third of time; organic work-up including cardiac catheterization negative.	Father was out of work for two years because of severe chest pains; because of family financial problems, patient got a job which aggravated his symptoms.	No symptoms during pediatric hospitalization, patient did not keep any pediatric outpatient appointments following his discharge.
10	14/W/M	Seven-month history of back pains; organic work-up including myelogram was negative; past history of being struck in lumbar region with baseball bat at age 5 years.	Mother overprotective; child had history of school phobia.	Followed as outpatient in Pediatric Clinic, symptoms subsided without recurrence.
11	13/W/F	G.I. symptoms age 5, cardiovascular symptoms age 7, no organic disease found, febrile and joint illness reported prior to current pediatric admission. History of repeated hospitalizations.	Only child of older parents born after 18 years of married life; sexually molested age 5; dislike for males.	Symptoms persisted during pediatric hospitalization. Discharged with referral to Child Psychiatry Clinic. Parents never kept appointment.
12	15/W/F	Three-year history of left hip pains; several hospital admissions; organic work-up negative including muscle biopsy.	Mother had history of nervous breakdown.	Pains ceased during pediatric hospitalization without medication; patient did not keep Pediatric O.P. Clinic appointment.
13	14/W/F	Three months prior to pediatric admission pains on left side; these pains had been intermittent for six years; organic work-up negative.	Parents divorced, mother's second marriage lasted only two months.	Pains ceased during pediatric hospitalization; year later admitted to child psychiatry inpatient service for school phobia; diagnosis: asthenic personality disorder.
14	13/W/F	Vague recurrent epigastric pains for six months prior to admission; organic work-up negative; shy, alert child.	Amish family. Onset of pains associated with arrival of uncle into family; patient did not get along with uncle.	Pains ceased during pediatric hospitalization. No follow-up after discharge.
15	14/W/F	Three-year history of arthralgia and myalgia; severe epigastric pains three months prior to admission; organic work-up negative. Seemed depressed.	Mother chronically ill and was reported to have had two heart attacks; parents fought and argued frequently about the children; sister diabetic.	Patient responded to reassurance and she had no epigastric pains at time of discharge. Nine months after discharge, she was seen in Pediatric Clinic because of left precordial pains radiating to axilla. Patient again responded to reassurance.

CASES REFERRED TO THE CHILD PSYCHIATRY CLINIC

TOTAL CASES REFERRED: 317

	Less than 6 years		6-12 years		13-16 years	
	M	F	M	F	M	F
White (W)	14	5	105	42	65	55
Negro (N)	1	2	10	4	9	5
Totals:	15	7	115	46	74	60
	22		161		134	
Conversion Symptoms	0	0	1(W)	2 (W)		1 (N)
	0		3		1	
% Conversion Symptom by Developmental age:	0		1.8%		0.7%	
Total % Conversion Symptom under 17			1.3%			

Fig. 1

CHILD PSYCHIATRIC CONSULTATIONS FOR THE PEDIATRIC IN-PATIENT SERVICE

TOTAL CASES REFERRED: 50

	Less than 6 years		6 - 12 years		13 - 16 years	
	M	F	M	F	M	F
White (W)	3	1	11	6	12	15
Negro (N)			1 (N)		1 (N)	
	3	1	12	6	13	15
	4		18		28	
Conversion Symptoms	0	0	3(W)	0	4 (W)	4 (W)
	0		3		8	
% Conversion Symptoms by Developmental age:	0		16.7%		28.6%	
Total % Conversion Symptom under 17:			22%			

Fig. 2

CASES REFERRED TO CHILD PSYCHIATRY INCLUDING PEDIATRIC IN-PATIENT REFERRALS

TOTAL CASES REFERRED: 317 + 50 = 367

	Less than 6 years		6-12 years		13-16 years	
	M	F	M	F	M	F
Cases referred:	18	8	127	52	87	75
Totals:	26		179		162	
Conversion Symptoms	0	0	4	2	4	5
	0		6		9	
% Conversion Symptoms	0%		3.4%		5.5%	
Total Conversion Symptoms under 17			4.1%			

Fig. 3

ROCK'S CASES REFERRED TO CHILD PSYCHIATRY, TRIPLER HOSPITAL - SEPT, 1968 through AUG. 1970

TOTAL CASES REFERRED: 196

	Less than 6 years		6-12 years		13-16 years	
	M	F	M	F	M	F
Cases Referred	16	5	92	37	26	20
Totals	21		129		46	
Conversion Reaction	1	1	2	2	0	1
	2		4		1	
% Conversion Reaction by Developmental age	9.5%		3.0%		2.2%	
Total % of C. R. under 16			3.6%			

Fig. 4

ercentage of conversion reactions diagnosed in he 6- to 12-year age group was about the same. In he under-six age group, no patients were diag-osed by the authors compared to two by Rock.[1] 'here were four times as many Missouri patients 1 the 13 to 16 age group and the percentage of onversion symptoms was 5.5% compared to Rock's[1] .2%. However, Rock[1] noted that the cut-off age or treatment was 14 and not 16 years, which may ccount for the low number of cases seen in his roup.

ISCUSSION

Comparison of the Missouri conversion patients ith the Hawaii conversion patients revealed the ollowing similarities:

1. Most patients were referred by physicians or medical centers.
2. The somatic motor and sensory symptom initially suggested organic disease for which the patient received a medical workup.
3. Overdependency was present in most of the children and overprotective attitudes were present in many mothers.

Differences between the Missouri and Hawaii onversion patients included the following:

1. The Missouri-patient symptoms were primarily somatic pain while the Hawaii-patient symptoms were motor or sensory losses of function.
2. Missouri patients came from a homogeneous rural population while the Hawaii patients were a heterogenous group of dependents of Army personnel from all parts of the world.
3. A greater frequency of occurrence of symptoms occurred in the Missouri teenage group in which there were four times as many patients evaluated.
4. No diagnosis of conversion symptom was made in the Missouri patients under six years of age despite a greater number of patients evaluated (compared to the same age Hawaii group) in this age group.

The literature reported varying incidence rates for conversion reactions in populations of children diagnosed with psychiatric disorders. Forbis,[6] in 1963-1964, reported 22 children with hysteria from a total of 128 (17%) child psychiatry referrals. In 1957, Proctor[7] diagnosed hysteria in 25 of 191 (13%) cases referred to child psychiatry. Schneer,[7] commenting on Proctor's paper, stated that there were only 15 of 1,421 (1%) child inpatients and eight of 1,596 (.5%) outpatients diagnosed as childhood hysteria at Kings County Hospital, New York between 1954 and 1957. Robins[8] searched the medical records of all children treated at St. Louis Children's Hospital and found 41 diagnosed as "hysteria" from a total sample of 1,029 (4%) children who were given any psychiatric diagnosis. When children who were diagnosed only as mentally retarded were excluded, the figures became 41 of 432 children (8.3%). Incidence rates depended on geographic and cultural factors as well as criteria used for diagnosis, the source of referral and the nature of the treating agency.

Because of the different criteria used for determining diagnoses, the incidence rate reported in this study could not be compared with these earlier studies. A more relevant comparison could be made with Rock's[1] study since a deliberate attempt was made to use the same criteria for diagnosing conversion symptoms and reactions. The overall incidence rate of 4.1% for conversion symptom patients from a sample of all child psychiatry referrals compared closely with Rock's[1] overall 3.6% incidence rate.

The 1.3% incidence of conversion symptom reactions first diagnosed at the Mid-Missouri Mental Health Center probably is an accurate frequency for clinics not associated closely with pediatric referral sources, while the 4.1% incidence would be applicable to clinics closely associated with a pediatric referral source. Clinics serving rural populations, such as Proctor's,[7] have reported a higher incidence rate among child psychiatry populations. Despite serving a rural area, the Mid-Missouri Mental Health Center would be considered to have a low rate (1.3%) for the diagnosis of conversion symptoms in referred children.

Proctor[7] also reported a higher incidence of hysteria in blacks (33%) compared to the number of Negroes (10%) in the total clinic population. In the Missouri study, only one Negro in 15 patients (6.7%) was diagnosed as having conversion symptoms while there were 33 Negroes in the 367 total child psychiatric population (8.9%). This would indicate, if anything, a lower incidence rate than the white population (3% vs 4%). The ratio of males to females in the Missouri study was fairly equal (54% male), which seems to contradict other studies[6, 8-10] that stressed female preponderance.

TABLE 3

MANAGEMENT OF CONVERSION SYMPTOMS

1. Give complete physical examination for each new symptom and, if indicated, perform the necessary laboratory tests.
2. Interpret the physical examination and laboratory test results to the parents with avoidance of ambiguity and uncertainty.
3. Unless there is definite evidence of physical disorder, give a clean bill of health to the parents and the child.
4. Reenforce health by positive suggestions.
5. Non-reenforcement of symptoms by lack of attention and return to school.
6. Correct environmental stress factors.
7. Counsel the parents specifically in regard to management of the physical complaint.
8. Maintain ongoing communication between school, parents and doctor.
9. Provide the child with outlets for energy and emotions, such as physical activity and recreation.

The higher frequency of conversion sympto diagnosed in the pediatric patients seen by t child psychiatry consultant indicated that patie having this type of disorder were more likely to seen initially at a primary medical care facili Some of these patients eventually were referred a psychiatric facility while other patients w treated successfully by the non-psychiatrist. doubt, there were children with conversion sym toms who were never referred for psychiatric c sultation since their doctors continued to sear for organic pathological findings or initiated so form of medical treatment. Follow-up repo were available for ten of 11 patients seen by t child psychiatry consultant. Three patients w transferred from the pediatric to a psychiatric cility for treatment; one patient was admitted the child psychiatry inpatient service a year lat for school phobia; one patient was referred to t child psychiatry service but failed to keep any a pointments; three patients' symptoms ceased d ing pediatric hospitalization following the co pletion of the organic work-up and a firm stand the pediatric staff that there was nothing physical abnormal; one patient had no symptoms after d charge and supportive pediatric outpatient ca and one patient's symptoms ceased prior to d charge only to have new conversion symptoms a follow-up visit in the Pediatric Clinic.

Implications

The families of patients predisposed to havi conversion symptoms are more oriented to medic problems (rather than emotional behavioral pro lems) and medical solutions offered by non-psyc atric medical personnel. Some of the families patients diagnosed as having conversion sympto do not follow through with an offhand referral a psychiatric service because of their need to de that an emotional problem could exist. Prima care physicians need to carefully explain to su families the reason for a psychiatric referral. some cases, it is wise to arrange for the appoin ment directly with the psychiatrist.

Although referrals to psychiatry are indicat for severe disorders, the treatment of mild diso ders by the primary care physician remains a di tinct possibility. (See Table 3 for the author's su gestions regarding the management of conversi symptoms.) The early recognition of conversi symptoms and the therapeutic attitudes of the p mary care physician will determine the eventu

(Continued on page 604)

GORDON C. SAUER, M.D., ***Kansas City***

Transverse Myelitis and Paralysis From a Brown Recluse Spider Bite

Case Report

An unusual case of transverse myelitis due to a brown recluse spider bite is reported. Six years later, the young man still has partial paralysis, walks with a crutch and has stress incontinence. It is known that the venom produces intravascular hemolysis along with changes in the clotting mechanism forming microthromboses. In this case, the anterior vertebral artery at T. 10 was occluded. Dr. Sauer is in the private practice of dermatology.

ITES DUE TO THE BROWN RECLUSE SPIDER (*Loxosceles eclusa*) were first recognized as such in 1957 by tkins, Wingo and Sodeman[1, 2] at the University of Missouri. The subject has been reviewed in recent rticles.[3, 4]

The bites Atkins noted were similar to the “ganrenous spots” or cutaneous arachnidism that was en in the South American countries of Chile and raguay.

The venom of Loxosceles spiders contains toxins hat cause tissue necrosis and activitation of clotng mechanisms in the vessels in the vicinity of he wound. This can result in extensive sloughing ith exposure of the underlying tissues.[5]

Many bites are noticed in the morning because he patient was bitten after rolling over on the pider during the night or patients are bitten when hey put on clothes containing the spider. Varying ith the amount of venom injected, a thick wheal rms that is usually pruritic. Mild bites have been eported by Berger.[6] In severe bites, a necrotic enter develops that becomes more prominent in hree or four days. Sloughing of the necrotic tissue ccurs in seven to ten days. The amount of reacon depends on the amount of poison injected and, ossibly, on the immunity of the individual.

The author has observed more than 20 moderate severe bites and the clinical lesion is always uite characteristic.

Therapy for the severe reactions is most effective begun early. It consists of cortisone by intrauscular injection or cortisone injected locally ound the lesion or both. This latter technique not approved by all clinicians.

Systemic reactions and, rarely, death have been ported, but the following case represents the ly reported instance of paralysis.

ASE REPORT

The patient was a 19-year-old white male college udent.

He stated that in the early morning of July 26, 1967, awoke with pain across his chest and he became restless. Later in the morning, he noted numbness of his legs and progressive loss of motion. He had slept that night in his shorts and without a sheet.

The mother suggested that he might have been bitten by a spider since she had killed a large one in his room two days after the onset of this problem. The family lived on a farm in Central Missouri.

The patient was hospitalized near his home, but he was transferred to Research Hospital in Kansas City on July 27.

On admission, Dr. Revis Lewis found that he had paralysis of both legs, incontinence of bowel and bladder and that pain and temperature sensations were absent up to the costal margin. Position sense and touch were present over the lower extremities. There was a small reddened area on the right buttock which Dr. Lewis thought might have been a needle puncture. Knee jerks and ankle jerks were absent.

I saw the patient on July 30, four days after the onset of illness. Examination then revealed a 3 cm × 4 cm area of black necrotic tissue with bullae on the coccygeal area. Surrounding this in a characteristic eccentric pattern was a red indurated area that spread 10 cm over the right buttock and slightly on the left buttock.

The black eschar on his coccygeal area eventually ulcerated down to a depth of 1 cm. On discharge of the patient on September 19 after 54 days of hospitalization, the ulcer had almost healed. The patient had recovered partial motion in the right leg and was able to wiggle the left foot and ankle. Bladder tone was gradually regained and bowel incontinence decreased.

Treatment consisted of other supportive measures and management of his bladder paralysis by Dr. L. Johnson. The patient was given 200 mg hydrocortisone sodium succinate (Solu-Cortef) daily for three days, along with 32 mg of triamcinolone a day for five days. The dosage decreased gradually, ending on September 1.

All laboratory tests, including a thoracic myelogram, were normal except for high blood glucose on two occasions, a 12,000 white blood cell count on admission and pyuria on one occasion during hospitalization.

In the last week of his hospitalization, the patient was able to walk with crutches and had 60% function returning in both legs.

The discharge diagnosis was "Transverse myelitis from occlusion of anterior vertebral artery at T.10 from a brown recluse spider bite of right buttock."

The patient was then referred to the University of Missouri Medical Center where he was hospitalized for 18 days to receive physiotherapy. He was discharged with a brace on his left leg.

By July, 1968, he was wearing no brace but was walking with one Lofstrand crutch. His gait was somewhat spastic and scissors-like. He also had continu stress incontinence.

He graduated from college and, as of 1974, is m ried, works part time on a farm and in an office, s uses a crutch for most walking and is incontinent occasions. There had been no improvement in th problems in the prior three to four years.

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Incidence of Conversion Symptoms

(Continued from page 602)

disposition and outcome of patients with conversion symptoms.

Summary

The authors found the occurrence of conversion symptoms in children evaluated initially at a mental health center to be 1.3% and the occurrence of conversion symptoms in patients referred directly from a pediatric inpatient unit to be 22%. Comparison with a similar study done by Rock showed a higher percentage of conversion symptoms in the 13-to 16-year group and an absence of symptoms in the under-6-year group. The 15 Missouri patients diagnosed with conversion symptoms included eight boys (54%) and seven girls (46%). The patients lived in rural areas and complained mainly of somatic pain. The research indicated that in most cases, patients with conversion symptoms we initially seen by primary care physicians. Sugg tions are given for the management of conversi symptoms by the physician.

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The Missouri Academy of Family Physicians will hold its 27th Annual Scientific Assembly on November 6-9, 1975 at the Lodge of the Four Seasons, Lake Ozark.

The annual session will be preceded this year by a Sports Festival on November 6, which will include tournaments in golf, tennis and bowling. The scientific program will begin at noon on November 7 and will continue through November 9. The program has been approved for 15½ prescribed hours by the AAFP.

Registration fee is $35 for members and $50 for nonmembers. For additional information, write to Gary L. Schnedler, Executive Secretary, Missouri Academy of Family Physicians, 223 Professional Bldg., Springfield, Mo. 65806.

ELLIOTT FRANKS, M.D. *and*
WALTER HARVEY JACOBS, M.D., *Kansas City*

holestatic Jaundice Possibly Due
o Benzodiazepine-Type Drugs

Case Report

ENZODIAZEPINE-TYPE DRUGS are among the most
tensively used medications in America. In 1972,
ore than 77 million prescriptions for these drugs
ere filled at retail pharmacies. More than 50 mil-
on of these prescriptions were for diazepam and
nother 4 million for flurazepam. Pharmaceutical
gents of the benzodiazepine class also are widely
escribed for hospitalized patients.[1] Relatively few
de effects have been reported. Recently, however,
e treated a woman with jaundice associated with
nzodiazepine drug therapy.

This is a case report of cholestatic jaundice with peripheral eosinophilia associated with the use of benzodiazepine drugs. The authors conclude that the jaundice should be considered in any patient who is taking one of this class of drugs and has an abnormal liver function. Dr. Jacobs is Chairman of the Department of Medicine and Head of the Goppert Gastroenterology Laboratory and Dr. Franks is a Resident at the Menorah Medical Center.

ASE REPORT

First Admission: A 40-year-old white woman was
lmitted to Menorah Medical Center on Feb. 8, 1974
ith the chief complaint of cough of one week's dura-
on, producing purulent sputum and associated with
spnea. Physical examination on admission revealed
lateral wheezes and rhonchi. Significant past medical
story included an appendectomy at age 13 and the
e of diaminodiphenylsulfone (Dapsone®) for many
ars as treatment for an undiagnosed skin eruption.
amily history was noncontributory. The patient reg-
arly smoked two packs of cigarettes a day.

Initial complete blood cell count, chest X-ray, elec-
ocardiogram and urinalysis were normal. Initial PO_2
as 66 mmHg; PCO_2 was 54 mmHg. She responded
ell to tetracycline, oxygen, aminophylline and inter-
ittent positive pressure breathing (IPPB). A SMA-
analysis, drawn on the morning after admission, re-
aled a total bilirubin of 0.4mg%, alkaline phosphatase,
IU; serum glutamic-oxaloacetic transaminase,
GOT) 40 IU; and lactic acid dehydrogenase (LDH),
0 IU. No further laboratory studies were performed
ring this admission. During this hospitalization, she
so received 15 mg to 30 mg of flurazepam (Dal-
ane®) at bedtime and 150 mg chlorpromazine (Tho-
zine®) spansules twice a day and started on the day
fore dismissal. She was discharged in good condition
Feb. 17, 1974.

Second Admission: The patient was readmitted on
b. 24, 1974 because of productive cough and fever.
ysical examination at that time revealed a tempera-
re of 100.4F and wheezes bilaterally. Diamino-
phenylsulfone was the only medication she admitted
taking in the interval between hospitalizations. A
orough review of systems indicated anorexia and
uritis.

SMA-12 revealed a total bilirubin of 2 mg/100 ml; alkaline phosphatase, 175 IU; LDH, 495 IU; SGOT, greater than 250 IU; and eosinophil count, 4%. Aminophylline, doxycyline (Vibramycin®), flurazepam, diazepam (Valium®), acetaminophen, dimenhydrate (Dramamine®) and doxepin (Sinequan®) were prescribed.

Because of the abnormal liver function studies, a liver scan was performed on February 24. It was interpreted as normal. On February 25, diazepam and doxycycline were discontinued; she was now receiving cephalexin (Keflex®), Brondecon®, KCl elixir, flurazepam and doxepin. SGOT was then 63 IU; LDH 170 IU; alkaline phosphatase, 206 IU; total bilirubin, 1.2 mg/100 ml. with a direct fraction of 0.6 mg/100 ml. Ten per cent of the peripheral leukocytes were eosinophils. On February 27, alkaline phosphatase was 198 IU and Bromsulphalein (BSP) retention was 10%. On February 28, SGOT was 588 IU; alkaline phosphatase, 588 IU; and GGTP, 291 (normal less than 30). Chlodiazepoxide (Librium®) was added by her physician.

We were consulted on March 6 because of the hepatic dysfunction. Her most recent laboratory studies revealed a white blood cell count of 9,700 with 37% eosinophils; SGOT, 202 IU; SGPT, 304 IU; alkaline phosphatase, 780 IU; GGTP, 272 IU. Total bilirubin was 5.2 mg/100 ml with a direct fraction of 3.8 mg/100 ml. Both flurazepam and chlordiazepoxide were discontinued at our recommendation.

On March 7, SGOT was 270 IU; SGPT, 420 IU; total bilirubin, 8.9 mg/100 ml with 6.0 mg/100 ml direct; and alkaline phosphatase, 684 IU. Leukocyte count was 10,800 with 16% eosinophils.

After discontinuation of all benzodiazepine drugs, the following laboratory values were obtained:

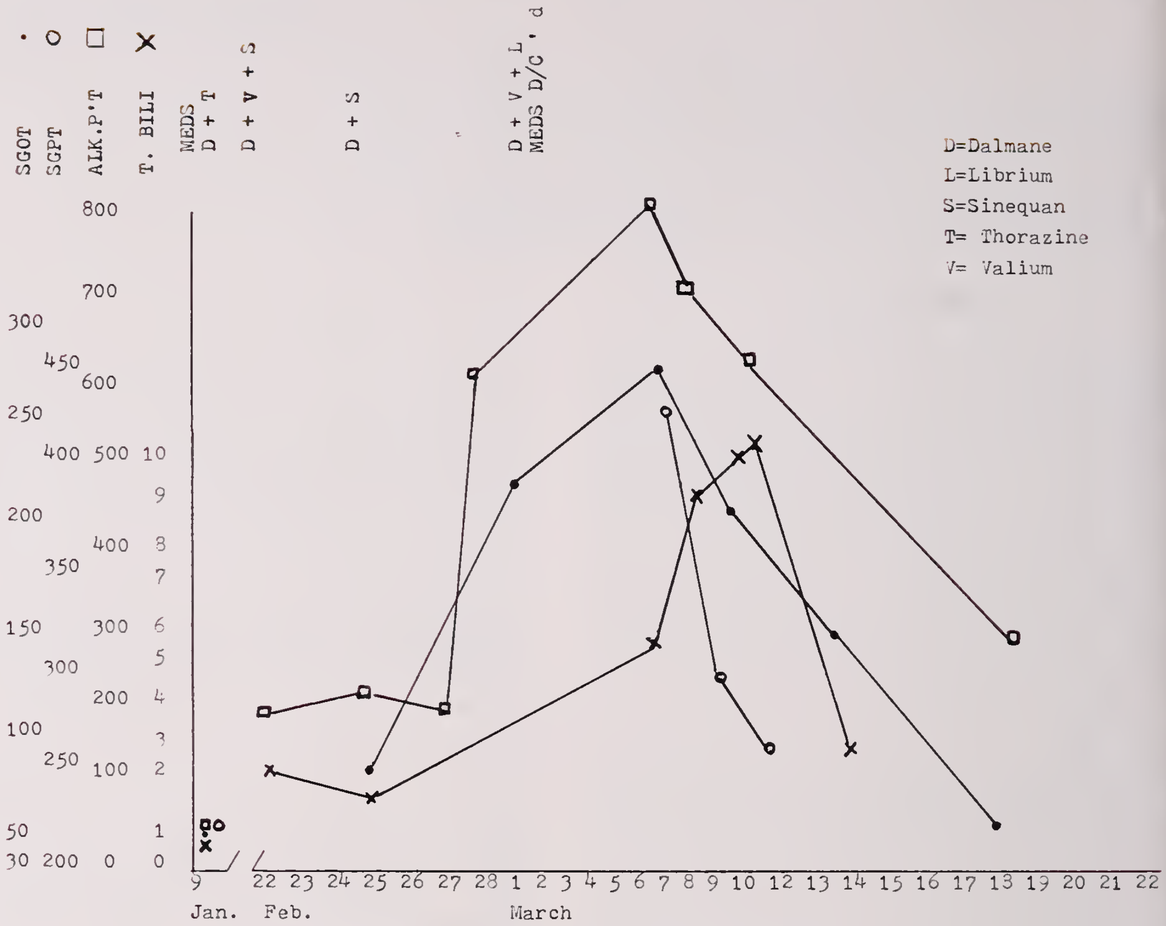

Fig. 1 Relation of Liver function to drug exposure.

Date	*WBC/Eos.*	*SGOT*	*SGPT*	*Bili. T/D*	*Alk. P'tase*
3-9		217	280	9.3/8.0	
3-11		159	248	9.7/7.5	
3-14	8,900/16%	140		5.4/3.0	546
3-18	6,100/17%	60		2.4/1.9	258

A liver biopsy was performed during peritoneoscopy on March 20. Microscopic examination of the specimen revealed intrahepatic cholestasis with a mild increase in eosinophils in focal inflammatory areas. The patient continued to improve and was discharged in good condition on March 22.

DISCUSSION

The patient's liver function studies in relation to her medication history during the period in question are shown graphically in Fig. 1.

The association between benzodiazepine drugs and cholestatic jaundice is becoming increasingly more evident.[2-6] Pathologic examination of the liver biopsy specimen revealed a pattern classically associated with cholestatic hepatitis.[7] It is evident from Fig. 1 that the derangement in this patient's liver function studies coincided with the administration of the benzodiazepine drugs and reverted to normal when they were discontinued. The fluctu tions in the various chemistries were closely relat to the administration of flurazepam.

SUMMARY

Benzodiazepine drugs are prescribed for ma reasons and often in the belief that they are v tually without adverse side effects. Cholestatic jau dice is becoming increasingly more commonly re ognized in association with benzodiazepine usa and should be considered in any patient with a normal liver function and who is taking any of th class of drugs.

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PHILIP C. ANDERSON, M.D., ***Columbia***

ypical Cases of Tapir Lip: Visual Diagnosis

Case Reports

APIR LIP is a useful, presumptive and visual diag- osis which can facilitate the physician's search r the precise diagnosis while allowing him to vise the patient immediately. In consulting and aching, these immediate visual entities are be- ming a more valuable part of our medical lan- age. I wish to report two instances of tapir lip in issourians (Table 1). The first (Fig. 1) is a rare d difficult problem; the second is a typical and mmon case. These cases illustrate the specific ethods for finding the successful final diagnosis d therapy.

ase Reports

Case # 1. A 47-year-old man was sent to the Univer- y Medical Center for evaluation of a fungus disease ich had extended slowly over his skin for almost 25 ars since military service in New Guinea. By the end the war in 1945, various treatments had not been ective. After another decade of consulting many ysicians and druggists, he resigned himself to having lisfiguring scaling dermatosis over 75% of his skin.

In August, 1963, after the extraction of some teeth, e papulosquamous disease flared and the upper lip ne enlarged. He was seen in our outpatient clinic. part of a general medical examination, scrapings re made from the skin and a previous biopsy was iewed. By direct microscopy and culture of the gus, Trichophyton rubrum, the first diagnosis was de of erythroderma due to trichophytosis. The lip s presumed to be a Trichophyton granuloma, and egimen of 1.5 gm of griseofulvin daily was ordered. three weeks, the generalized dermatophytosis was nost eliminated, but the tumorous enlargement of e upper lip had worsened. After eight weeks of treat- nt, the body skin was wholly clear, but the upper was firmer and even more enlarged and pigmented getations had appeared on the skin (Fig. 2) giving n the facial appearance of a tapir.

He was admitted to the University of Missouri Hos- al. In addition to a general examination, our original ecial medical studies included a complete blood int, serologic tests for syphillis (STS), chest x-ray, toplasmin complement fixation and skin tests to ichophyton, coccidioidin, blastomycin and tuberculin. abnormalities were found.

We pursued the diagnosis of tapir lip by making eper excisions from the lip for culture and biopsy. ay examinations of the head, electrophoresis of serum, determinations of serum bromides, calcium and phosphate and general febrile agglutinins were completed. The useful result was that an ovoid organism was seen in tissues of the lip by the Grocott stain and was recovered by culture.

Special stains and cultures, including some done at the Communicable Disease Center of the U. S. Public Health Service, did not resolve the exact identity of the fungus, although we presumed it was an atypical Sporothrichium schenkii. Because the organism did not convert to the yeast phase at 37 degrees, final agreement as to species never was achieved. However, we acted on this partial evidence by gradually increasing the dose of potassium iodide solution to 45 drops daily as adequate treatment for sporotrichosis. The lip healed rapidly and completely, and the disease has not recurred in 11 years. My final diagnosis would be tapir lip due to a fungus, presumably sporotrichosis. I think

TABLE 1

TAPIR LIP:
SUGGESTED DIFFERENTIAL DIAGNOSES

- *Acute or Recurring*
  - Trauma
  - Angioedema, primary
  - Erysipelas
  - Severe herpes simplex
  - Fixed drug reaction
- *Sustained*
  - Lymphedema, post-infection[2]
  - Vegetative pyoderma, primary or secondary to nasal discharge
  - Sporotrichosis
  - Histoplasmosis*
  - Bromoderma
  - Hemangioma, lymphangioma
  - Cancer-sarcoma, epithelioma*[3, 4]
  - Syphilis, gumma*[5]
  - Lupus erythematosus
- *Very Rarely**
  - Leishmaniasis
  - South American Blastomycosis
  - Tuberculosis
  - Rhinosporidiosis
  - Melkerson-Rosenthal syndrome[6, 7]
  - Ascher's syndrome[8]

*Inclusion suggested to me by associates or only from pictures.

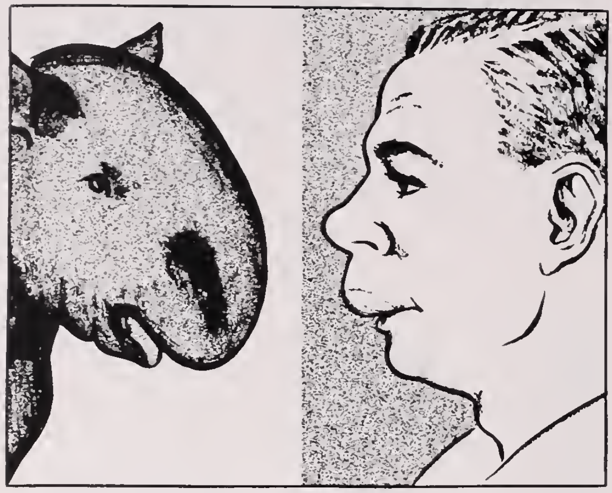

Fig. 1 The face of the Tapir is dominated by the upper lip. Five species of this shy, nocturnal mammal inhabit the woodlands of South and Central America and Malay. The clinical term, Tapir lip, describes patients with persistent enlarged upper lips.

that the sustained severe trichophytosis was one cause of an increased susceptibility to infection by a second fungus.[1]

Case # 2. A 20-year-old actress had been partially disabled by severe recurrent herpes simplex infections of the upper lip, which had worsened since early te age. A mild sunburn commonly incited an episode herpes. Six to eight infections a year routinely invol half of the upper lip and, occasionally, other small si on the face. The edema and ulceration of the lip w disfiguring in her work and interfered with her spee When performing on the stage her practice was cauterize the lesions with styptic pencil daily a conceal them with heavy stage makeup. During t year 1972, prior to our therapy, she became aw that the lip was remaining mildly swollen betwe herpetic infections. Suddenly, she developed a markably disfiguring tapir lip.

Her first visit to our medical center was for t exceptional problem which included acute fever a malaise, severe pain and swelling in the skin over t lip and left nostril. The skin was tense and warm the touch and extremely tender. Our diagnosis v erysipelas, secondary to herpes simplex. As is often t case, the streptococcus was not recovered in cult but, ten weeks later, ASTO titer was increased. T distinctive clinical picture and the quick response penicillin were persuasive. The acute problem was solved in two days.

Three lines of treatment for the residual disfigu ment were started; first, long-term penicillin thera was necessary to prevent recurrent streptococcal inf tion in the damaged lip; second, strict protection of t

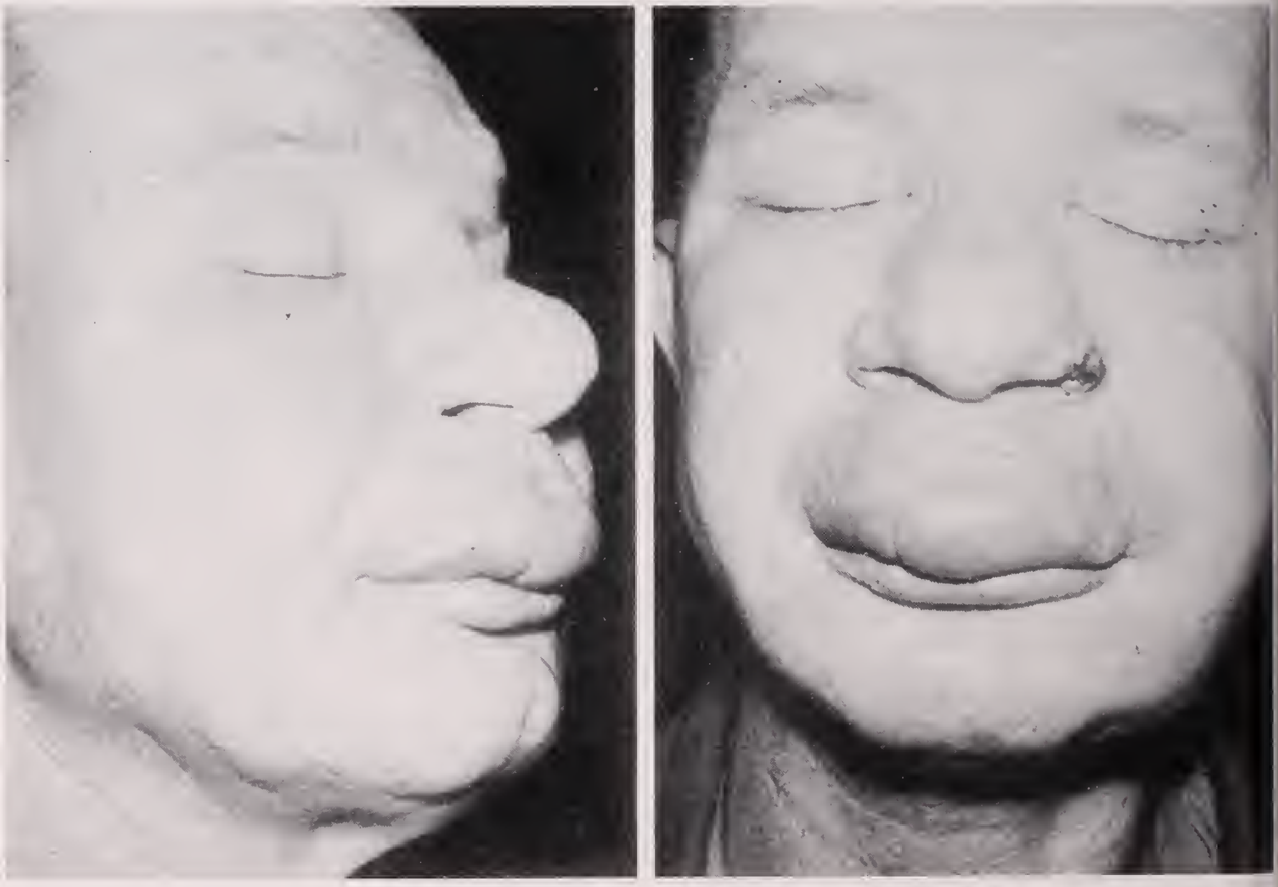

Fig. 2 This man's tapir lip enlarged slowly for six months before erosions and vegetations developed on the no The lower lip was not involved.

was provided by topical sunscreens; and, finally, atment was given to the active herpes with a milder minum chloride solution, while avoiding occlusive keup. In six months, the tapir lip appearance had gressed to normal. Perhaps because the patient rigor- sly avoided sunlight, she was fortunate to have only e further herpes infection in the year.

Persistent lymphedema after bacterial infection the most common cause of chronic tapir lip. vere trauma or herpes simplex infections may gin the problem; erysipelas often is the real use. Careful evaluation and prompt care may event a permanent disfigurement, and reduce sability to a minimum.

ISCUSSION

Tapir lip is a particularly distinctive, visual clini- l entity within the general group of macrochelia. ithout a well-planned strategy, the immediate portunity to diagnose and treat it may be lost d, therefore, the immediate visual recognition of pir lip served these two patients well by alerting e physician. Tapir lip differs from plain macro- elia in the severity of swelling, in the sparing of e lower lip and lower face and in showing close alization of the tumor to the central part of the per lip including the base of the nose. Localiza- n to a small central area of the lip causes the stinctive tapir look. The management of tapir is simpler than that of all types of macrochelia. e medical literature does not emphasize pre- mptive visual diagnosis or encourage case reports ich illustrate medical evaluation methods other n those concerned with exact diagnosis. Because mediate therapy may prevent disfigurement to a tient, such as the actress, early expert case han- ng is easily as important as ultimate diagnosis, owing that both are needed eventually.

The tapir lip syndrome may be explained by atomy. I speculate that the upper lip is a penin- lar flap of skin which is a sanctuary for infection cause of both limited lymphatic return and ham- red access by immunologic defenses. Such sanc- ary is only partial and the balance is unstable. erefore, unusual mixed or severe types of chron- granulomas occur, clinical evolution may not be expected and organisms may be difficult to re- ver. Case # 1 illustrates this point. I conclude t the Sporotrichum was modified in the peculiar granuloma causing the in vitro growth charac- istics to resemble those of partially treated ease.

These case reports show that tapir lip is a simple, visual diagnosis for which explicit presumptions can be established so that delay can be minimized, the correct diagnostic strategy devised and rational treatment assured. Dr. Anderson is Professor and Chairman, Division of Dermatology, Department of Medicine, University of Missouri Medical Center.

In retrospection, to improve the medical management of the difficult Case # 1, I would immediately do several deeper incisions for biopsy and culture. The delay came from my reliance on the griseofulvin. Although the long trial of griseofulvin was rational, I now think that doing more extensive diagnostic cultures immediately would have improved our strategy. Today, I would be less concerned about the atypicality of any organism, such as the Sporotrichum, recovered from such severe granulomas in the lip. I would treat on reasonable identification, providing proper safety and clinical verifications were assured. Tooth extraction and other trauma in the mouth may predispose to odd mixed infections and, especially, to tapir lip as shown in Case # 1.

Tapir lip is a simple, visual diagnosis. Soft, edematous, evanescent tapir lip usually has a simple explanation and a good prognosis, as it did in my second patient. The nodular, firm, persistent tapir lip, which shows a dense granuloma on biopsy, may be surprisingly complex and dangerous without treatment. In either event, explicit diagnostic presumptions can be established for tapir lip so that delay can be minimized, the correct diagnostic strategy devised and rational treatment assured.

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President's Message

"Physician involvement" . . . something you always hear about, but never see. Well, I recently witnessed "physician involvement" and, let me assure you, it was great!!

I was fortunate enough to have the opportunity to attend the September meeting of the Greene County Medical Society in Springfield. Dr. Malcolm C. Todd, Immediate Past-President of the AMA, was the featured guest and speaker. The presence of Dr. Todd and the chance to hear him speak would have made the trip very worthwhile. But our colleagues in Greene County were to bestow many more pleasant experiences upon me during the two-day visit.

I'm sure that upon his arrival in Springfield, Dr. Todd had every intention of doing all he could for the physicians in Greene County and in Missouri. I'm just not sure he knew HOW MUCH he would be doing. I joined Dr. Todd in what might be described as a brisk trot through "all the gates" in Springfield.

Dr. Todd met with the press—including a half-hour television program—ate breakfast with area Legislators, addressed a high school assembly, spoke to about 300 medical society doctors and, would you believe it, talked with local labor leaders! Greene County physicians had planned a full schedule for Dr. Todd and he mastered it with ease. He made many new friends for medicine in Missouri.

R. Allen Chandler, M.D.

In attempting to keep up with the pace set for Dr. Todd, I became keenly aware that although Dr. Todd is a national spokesman and, thus, received the attention of the Springfield area citizens, the groundwork for this fine and effective man had been well laid by Greene County physicians.

Greene County physicians *know* their Congressman, their State Legislators, their high school students and, yes, even their local labor leaders. In other words, they are "involved" in their community!

It shows!

Due to the constant "physician involvement" by our Greene County colleagues, Dr. Todd was well received by a fair press, saw Legislative "key man" activity at its best, was asked interesting and informative questions by high school students and, during our lunch with labor leaders, found that these important leaders liked the idea of discussing areas of interest with doctors.

It's obvious I enjoyed my sojourn into Southwest Missouri. I enjoyed the opportunity to expand my friendship with Dr. Todd and have the chance to express the appreciation of all Missouri physicians for his efforts on our behalf.

Perhaps even more, I was proud that Dr. Todd had the opportunity to see our Greene County physicians in action. They offer a first-class example of what "physician involvement" can do for our profession and our patients.

Now, if we could only get other physicians to. . . .

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Mrs. William R. McPhee
President

The MSMA Auxiliary has a special interest in this exciting concept. We are proud to announce that our own member, Mrs. William M. "Pat" Walker of Springfield, is at the helm of this new national program and is sitting in the Director's Chair.

Each and every member or auxiliary may utilize this repository. First, a "deposit" can be made by sharing the details of a completed project in terms of size, available volunteers, funds, locale and other pertinent data. This deposited information then becomes a resource of the bank which is translated into a form anyone can use, indexed, cataloged for easy reference and filed. It is then available to county auxiliaries across the nation just for the asking.

Second, making a "withdrawal" is as simple as completing a request form. When a county or state auxiliary has a need, seeks the best way to accomplish a project by drawing on the experience of others and desires to cooperate more fully with others in developing and implementing a chosen project activity, it can draw from the PROJECT BANK.

In record time, this group will have in its hands tailor-made, proven program information from this one, easy-to-reach source. In addition, this bank has as a part of its assets program materials initiated by other health-related organizations. (Yes, even Uncle Sam has agreed to share his expertise with us.) Who could ask for more?

Ideally, this new program will provide a swift, efficient and practical avenue with which the national organization can assist in the development of community service projects at the state and county levels. It more fully utilizes the strength of the auxiliary and provides a way to update and improve the information flow. Most importantly, it encourages and fosters medical auxiliary activity in local communities where the need is the greatest and marshalls the forces of our impressive organization to help local groups meet these needs most effectively.

County Society News

FIRST DISTRICT

COUNCILOR
JOHN N. MARTIN, M.D., ST. JOSEPH

Buchanan County Medical Society

Fifty-nine persons attended the annual election and University of Missouri Medical Night of the Buchanan County Medical Society. The meeting was held on September 3 after a 12-course dinner at the Peking Rendezvous in St. Joseph.

Dr. William O'Connor presided at the session. The following members were elected to serve the Society in 1976: President-Elect, Dr. Richard O. Craig; Vice-President, Dr. Edmund W. Kline; Secretary, Dr. Carl K. Ness (reelected); Treasurer, Dr. Robert W. Kieber (reelected for the 23rd consecutive term); and Censor, Dr. John R. McDaniel.

Dr. Allen I. Herman and Dr. Charles N. Mullican were named Delegates to the MSMA. Alternates who were chosen are Drs. R. Philip Acuff, Gerald E. Fox, Berwyn H. Moen and Gordon S. Paulson. Dr. Robert R. Stuber was named to the Committee on Public Policy. Dr. Paul M. Beck was elected Trustee to 1981. Dr. O'Connor was selected as a member of the Executive Secretary Committee.

Joyce Kays from the Missouri Medical Alumni Associate office in Columbia arranged the program from the Medical Center and attended the meeting.

Dr. Acuff served as moderator for the progr Dr. William H. Ames introduced Dr. Joseph White, Provost for Health Affairs at the Med Center in Columbia. Dr. White gave an "Update the University of Missouri Medical Center."

Dr. F. James Marston, Jr., introduced Dr. Fr Mitchell, professor of surgery and director of Em gency Medical Services at the Medical Center. Acuff introduced Hillis Crowell, associate direc of the Center's Emergency Medical Services. T two men discussed "Emergency Medical Servi in Missouri."

Carl K. Ness, M.D., *Secret*

In Memoriam

L. St. Clair Shumate, M.D., Reeds Spring 65737, a graduate of Barnes Medical College, 1902; member Ozark Medical Society; age 95; died Aug. 21, 1975.

Jules H. Kopp, M.D., 23 Arbor Rd., St. Louis 63132, a graduate of the University of Arkansas, 1931; member St. Louis County Medical Society; age 68; died Aug. 23, 1975.

Frank E. Dinelli, M.D., 215 Oak, Poplar Bluff 63901, a graduate of St. Louis University, 1939; member Butler-Wayne-Ripley County Medical Society; age 60; died Sept. 5, 1975.

George A. O'Sullivan, M.D., 7629 Ivory Ave., St. Louis 63011, a graduate of St. Louis University, 1927; member St. Louis Medical Society; age 71; died Sept. 15, 1975.

EIGHTH DISTRICT

COUNCILOR
HOWARD J. McALHANY, M.D.,
SPRINGFIELD

Ozark Medical Society

The Ozark Medical Society met at Hill's R taurant in Neosho on Sept. 9, 1975 .

After a lively social hour and delightful din Dr. George W. Blankenship introduced the gu speaker, Dr. Ken Pottinger, a radiologist fr Joplin. Dr. Pottinger showed interesting x-ray fil Most of the members participated in the questi and-answer forum. The presentation was well cepted by the members.

Following the presentation by the speaker, business meeting was called to order by Presid Francisco R. Esparrago. There were 12 memb present.

Dr. Betz read the minutes of the previous me ing. They were accepted without correction.

The status of retired members was consider They are Dr. Robert R. Donley, Dr. Joseph Gardner, Dr. Leo T. Taylor and Dr. Melvin Bo man. It was proposed and approved that a reco mendation and request for honorary membersh be sent to the executive secretary of the MSMA.

Members of the Nominating Committee w voted on and approved. They are Dr. George Blankenship, chairman; Dr. Kenneth Glover a Dr. Mary Jane Merideth.

The next monthly meeting to be held in Cassvi was announced and accepted by Dr. Mary Me deth.

There being no further business, the meeting w adjourned.

Victor G. Occeno, M.D., *Secretary Pro T*

New Members

Lakhanagam G. P. Achar, M.D., 600 E. 22nd, ansas City 64108, has become a member of Jack- on County Medical Society. Dr. Achar is a native f India, received his preliminary education at entral College and his M.D. degree at Bangalore Iedical College in 1967. He specializes in psy- hiatry.

Gary D. Beauchamp, M.D., 4320 Wornall Rd., ansas City 64111, has become a member of Jack- on County Medical Society. Dr. Beauchamp is a ative of Paola, Kan., received his preliminary edu- ation at the University of Kansas and his M.D. egree at the University of Kansas in 1970. He ecializes in cardiology.

Walter F. Benoist, M.D., 500 Northwest Plaza, St. nn 63074, has become a member of St. Louis ounty Medical Society. Dr. Benoist is a native of t. Louis, received his preliminary education at the niversity of Pennsylvania and his M.D. degree at ashington University in 1972. He specializes in ediatrics.

Michael J. Bukstein, M.D., 711 Grand, Hannibal 3401, has become a member of Marion-Ralls- helby County Medical Society. Dr. Bukstein is a ative of Dayton, Ohio, received his preliminary ducation at Washington University and his M.D. egree at the University of Missouri in 1970. He ecializes in general and vascular surgery.

Adoracion Cadiz-Rojales, M.D., 2601 N. Whit- er, St. Louis 63113, has become a member of St. ouis Medical Society. Dr. Cadiz-Rojales is a native the Philippines, received her preliminary edu- ation at the University of Santo Tomas and her .D. degree at the University of Santo Tomas in 956. She specializes in pediatrics.

Antonio T. Cajili, M.D., 300 S. Grand, St. Louis 3103, has become a member of St. Louis Medical ociety. Dr. Cajili is a native of the Philippines, ceived his preliminary education at the University the Philippines and his M.D. degree at Manila entral University in 1954. He specializes in in- rnal medicine.

James R. Dzur, M.D., 14 Doctors' Park, Cape irardeau 63701, has become a member of Cape irardeau County Medical Society. Dr. Dzur is a ative of Livingston, Mont., received his prelimi- ary education at Oklahoma City University and his M.D. degree at Vanderbilt University in 1968. He specializes in endocrinology.

David Ellis, M.D., 751 E. 63rd, Kansas City 64110, has become a member of Jackson County Medical Society. Dr. Ellis is a native of Kansas City, received his preliminary education at the University of Illinois and his M.D. degree at the University of Missouri in 1969. He specializes in general surgery.

John S. Farrell, M.D., 1325 S. Grand, St. Louis 63104, has become a member of St. Louis Medical Society. Dr. Farrell is a native of Missouri, received his preliminary education at St. Louis University and his M.D. degree at St. Louis University in 1973. He specializes in internal medicine.

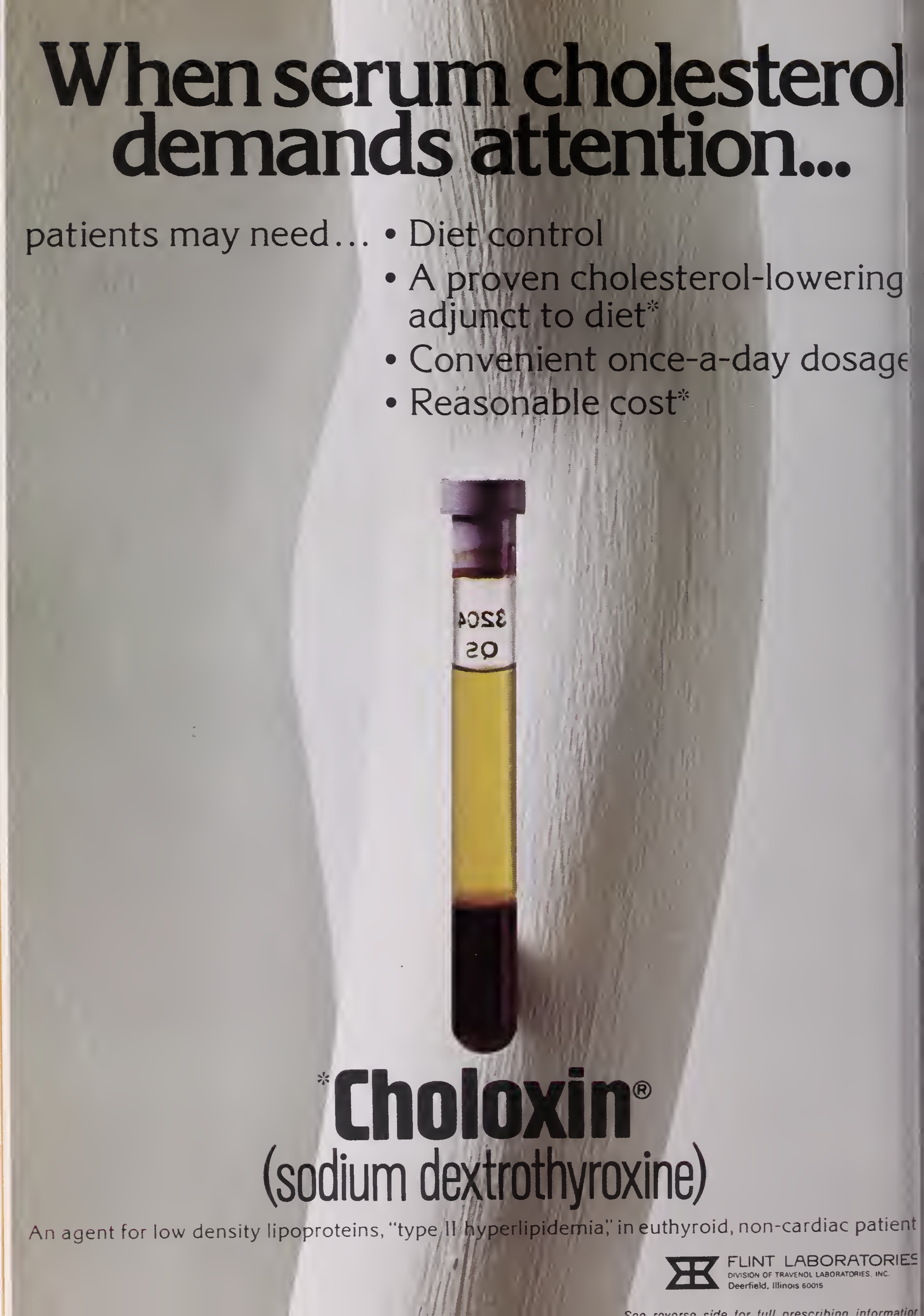
Bharathi B. Gottipatti, M.D., 711 Grand, Hannibal 63401, has become a member of Marion-Ralls-Shelby County Medical Society. Dr. Gottipatti is a native of India, received her preliminary education at Queen Mary's College and her M.D. degree at Stanley Medical College in 1963. She specializes in obstetrics and gynecology.

E. R. Habert, M.D., 1515 Lafayette, St. Louis 63104, has become a member of St. Louis Medical Society. Dr. Habert is a native of Mississippi, received his preliminary education at Louisiana State University and his M.D. degree at Louisiana State University in 1967. He specializes in radiology.

Murray Heimberg, M.D., 807 Stadium, Columbia 65201, has become a member of Boone County Medical Society. Dr. Heimberg is a native of Brooklyn, N. Y., received his preliminary education at Cornell University and his M.D. degree at Vanderbilt University in 1959. He specializes in pharmacology and clinic pharmacology.

Basharat U. Jazbi, M.D., 24th and Gillham Rd., Kansas City 64108, has become a member of Jackson County Medical Society. Dr. Jazbi is a native of Pakistan, received his preliminary education at Dow Medical College and his M.D. degree at the University of Copenhagen in 1968. He specializes in otorhinolaryngology.

Christopher H. Jung, M.D., 35 Doctors' Park, Cape Girardeau 63701, has become a member of Cape Girardeau County Medical Society. Dr. Jung is a native of New Jersey, received his preliminary education at the University of Missouri and his



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It has not been established whether the drug-induced lowering of serum cholesterol or lipid levels has a detrimental, beneficial, or no effect on the morbidity or mortality due to atherosclerosis or coronary heart disease. Several years will be required before current investigations will yield an answer to this question.

CHOLOXIN® (sodium dextrothyroxine) Single-Tablet-A-Day Dosage Schedules
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	Starting Dosage	Increased Monthly by	Usual Maintenance	Maximal Recommended
Adult Hypercholesterolemic	1.0-2.0 mg.	1.0-2.0 mg.	4.0-8.0 mg.	4.0-8.0 mg.
Pediatric Hypercholesterolemic	0.05 mg./kg. body weight	0.05 mg./kg.	0.1 mg./kg. body weight	4.0 mg.
Hypothyroid Cardiac	0.5-1.0 mg.	1.0 mg.	4.0 mg.	4.0 mg.

Choloxin®
(sodium dextrothyroxine)

Description
CHOLOXIN (sodium dextrothyroxine) is the sodium salt of the dextrorotatory isomer of thyroxine. It is chemically described as D-3,5,3′,5′-tetraiodothyronine sodium salt.

Actions
The predominant effect of CHOLOXIN (sodium dextrothyroxine) is the reduction of serum cholesterol levels in hyperlipidemic patients. Beta lipoprotein and triglyceride fractions may also be reduced from previously elevated levels.

Most of the available evidence indicates that CHOLOXIN stimulates the liver to increase catabolism and excretion of cholesterol and its degradation products via the biliary route into the feces. Cholesterol synthesis is not inhibited and abnormal metabolic end-products do not accumulate in the blood.

Indications
This is not an innocuous drug. Strict attention should be paid to the indications and contraindications.

CHOLOXIN (sodium dextrothyroxine) is an antilipidemic agent used as an adjunct to diet and other measures for the reduction of elevated serum cholesterol (low density lipoproteins) in euthyroid patients with no known evidence of organic heart disease.

The drug is also indicated in the treatment of hypothyroidism in patients with cardiac disease who cannot tolerate other types of thyroid medication.

Before prescribing, note the following: Results from a randomized clinical study have indicated a possible adverse effect when CHOLOXIN is administered to a patient receiving a digitalis preparation. There may be an additive effect. This additive effect may possibly stimulate the myocardium excessively in patients with significant myocardial impairment. CHOLOXIN dosage should not exceed 4 mg per day when the patient is receiving a digitalis preparation concomitantly. Careful monitoring of the total effect of both drugs is important.

It has not been established whether the drug-induced lowering of serum cholesterol or lipid levels has a detrimental, beneficial, or no effect on the morbidity or mortality due to atherosclerosis or coronary heart disease. Several years will be required before current investigations will yield an answer to this question.

Contraindications
The administration of CHOLOXIN (sodium dextrothyroxine) to euthyroid patients with one or more of the following conditions is contraindicated:

1. Known organic heart disease, including angina pectoris; history of myocardial infarction; cardiac arrhythmia or tachycardia, either active or in patients with demonstrated propensity for arrhythmias; rheumatic heart disease; history of congestive heart failure; and decompensated or borderline compensated cardiac status.
2. Hypertensive states (other than mild, labile systolic hypertension).
3. Advanced liver or kidney disease.
4. Pregnancy.
5. Nursing mothers.
6. History of iodism.

Warnings
CHOLOXIN (sodium dextrothyroxine) may potentiate the effects of anticoagulants on prothrombin time. Reductions of anticoagulant dosage by as much as 30% have been required in some patients. Consequently, the dosage of anticoagulants should be reduced by one-third upon initiation of CHOLOXIN therapy and the dosage subsequently readjusted on the basis of prothrombin time. The prothrombin time of patients receiving anticoagulant therapy concomitantly with CHOLOXIN therapy should be observed as frequently as necessary, but at least weekly, during the first few weeks of treatment.

In the surgical patient, it is wise to consider withdrawal of the drug two weeks prior to surgery if the use of anticoagulants during surgery is contemplated.

When CHOLOXIN is used as thyroid replacement therapy in hypothyroid patients with concomitant coronary artery disease (especially those with a history of angina pectoris or myocardial infarction) or other cardiac disease, treatment should be initiated with care. Special consideration of the dosage schedule of CHOLOXIN is required. This drug may increase the oxygen requirements of the myocardium, especially at high dosage levels. Treated subjects with coronary artery disease must be seen at frequent intervals. If aggravation of angina or increased myocardial ischemia, cardiac failure, or clinically significant arrhythmia develops during the treatment of hypothyroid patients, the dosage should be reduced or the drug discontinued.

Special consideration must be given to the dosage of other thyroid medications used concomitantly with CHOLOXIN. As with all thyroactive drugs, hypothyroid patients are more sensitive to a given dose of CHOLOXIN than euthyroid patients.

Epinephrine injection in patients with coronary artery disease may precipitate an episode of coronary insufficiency. This condition may be enhanced in patients receiving thyroid analogues. These phenomena should be kept in mind when catecholamine injections are required in sodium dextrothyroxine-treated patients with coronary artery disease.

Since the possibility of precipitating cardiac arrhythmias during surgery may be greater in patients treated with thyroid hormones, it may be wise to discontinue CHOLOXIN in euthyroid patients at least two weeks prior to an elective operation. During emergency surgery in euthyroid patients, and in surgery in hypothyroid patients in whom it may be advisable to withdraw therapy, the patients should be carefully observed.

There are reports that sodium dextrothyroxine in diabetic patients is capable of increasing blood sugar levels with a resultant increase in requirements of insulin or oral hypoglycemic agents. Special attention should be paid to parameters necessary for good control of the diabetic state in dextrothyroxine-treated subjects and to dosage requirements of insulin or other antidiabetic drugs. If sodium dextrothyroxine is later withdrawn from patients who had required an increase of insulin (or oral hypoglycemic agents) dosage during its administration, the dosage of antidiabetic drugs should be reduced and adjusted to maintain good control of the diabetic state.

When either or both impaired liver or kidney function are present, the advantages of CHOLOXIN therapy must be weighed against the possibility of deleterious results.

Usage in Women of Childbearing Age
Women of childbearing age with familial hypercholesterolemia or hyperlipemia should not be deprived of the use of this drug; it can be given to those patients exercising strict birth control procedures. Since pregnancy may occur despite the use of birth control procedures, administration of CHOLOXIN (sodium dextrothyroxine) to women of this age group should be undertaken only after weighing the possible risk to the fetus against the possible benefits to the mother. Teratogenic studies in two animal species have resulted in no abnormalities in the offspring.

Precautions
It is expected that patients on dextrothyroxine therapy will show greatly increased serum protein-bound-iodine levels. These increased serum PBI values are evidence of absorption and transport of the drug, and should NOT be interpreted as evidence of hypermetabolism; similarly, they may not be used for titrating the effective dose of CHOLOXIN (sodium dextrothyroxine). PBI values in the range of 10 to 25 mcg% in treated patients are common.

If signs or symptoms of iodism develop during CHOLOXIN therapy, the drug should be discontinued.

A few children with familial hypercholesterolemia have been treated with CHOLOXIN for periods of one year or longer with no adverse effects on growth. However, it is recommended that the drug be continued in patients in this age group only if a significant serum cholesterol-lowering effect is observed.

Adverse Reactions
The side effects attributed to dextrothyroxine therapy are, for the most part, due to increased metabolism, and may be minimized by following the recommended dosage schedule. Adverse effects are least commonly seen in euthyroid patients with no signs or symptoms of organic heart disease; the incidence of adverse effects is increased in hypothyroid patients, and is highest in those patients with organic heart disease superimposed on the hypothyroid state.

In the absence of known organic heart disease, some cardiac changes may be precipitated during sodium dextrothyroxine therapy. In addition to angina pectoris, arrhythmia consisting of extrasystoles, ectopic beats, or supraventricular tachycardia, ECG evidence of ischemic myocardial changes and increase in heart size have been observed. Myocardial infarctions, both fatal and non-fatal, have occurred, but these are not unexpected in untreated patients in the age groups studied. It is not known whether any of these infarcts were drug related.

Changes in clinical status that may be related to the metabolic action of the drug include the development of insomnia, nervousness, palpitations, tremors, loss of weight, lid lag, sweating, flushing, hyperthermia, hair loss, diuresis, and menstrual irregularities. Gastrointestinal complaints during therapy have included dyspepsia, nausea and vomiting, constipation, diarrhea, and decrease in appetite.

Other side effects reported to be associated with CHOLOXIN (sodium dextrothyroxine) therapy include the development of headache, changes in libido (increase or decrease), hoarseness, tinnitus, dizziness, peripheral edema, malaise, tiredness, visual disturbances, psychic changes, paresthesia, muscle pain, and various bizarre subjective complaints. Skin rashes, including a few which appeared to be due to iodism, and itching have been attributed to dextrothyroxine by some investigators. Gallstones have been discovered in occasional dextrothyroxine-treated patients and cholestatic jaundice has occurred in one patient, although its relationship to CHOLOXIN therapy was not established.

In several instances, the previously existing conditions of the patient appeared to continue or progress during the administration of CHOLOXIN; a worsening of peripheral vascular disease, sensorium, exophthalmos, and retinopathy have been reported.

CHOLOXIN potentiates the effects of anticoagulants, such as warfarin or Dicumarol, on prothrombin time, thus indicating a decrease in the dosage requirements of the anticoagulants. On the other hand, dosage requirements of antidiabetic drugs have been reported to be increased during dextrothyroxine therapy (see WARNINGS section).

Dosage and Administration
For **adult** euthyroid hypercholesterolemic patients, the recommended maintenance dose of CHOLOXIN (sodium dextrothyroxine) is 4 to 8 mg per day. The initial daily dose should be 1 to 2 mg to be increased in 1 to 2 mg increments at intervals of not less than one month to a maximum level of 4 to 8 mg daily, if that dosage level is indicated to effect the desired lowering of serum cholesterol.

When used as partial or complete substitution therapy for levothyroxine in hypothyroid patients with cardiac disease who cannot tolerate other types of thyroid medication, the initial daily dose should be 1 mg to be increased in 1 mg increments at intervals of not less than one month to a maximum level of 4 to 8 mg daily, preferably the lower dosage. The maximum in patients receiving digitalis therapy is 4 mg.

For **pediatric** hypercholesterolemic patients, the recommended maintenance dose of CHOLOXIN is approximately 0.1 mg per kilogram. The initial daily dosage should be approximately 0.05 mg per kilogram to be increased in up to 0.05 mg per kilogram increments at monthly intervals. The recommended maximal dose is 4 mg daily, if that dosage is indicated to effect the desired lowering of serum cholesterol.

If new signs or symptoms of cardiac disease develop during the treatment period, the drug should be withdrawn.

How Supplied
CHOLOXIN (sodium dextrothyroxine) is supplied in prescription packages of scored 1, 2, 4, and 6 mg tablets.

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M.D. degree at the University of Missouri in 1969. He specializes in otolaryngology.

Manoch Kuangparichat, M.D., 1028½ Main, Lexington 64067, has become a member of Lafayette-Ray County Medical Society. Dr. Kuangparichat is a native of Thailand, received his preliminary education at Mahidol University and his M.D. degree at Chiangmai University in 1968. He specializes in internal medicine and cardiology.

Yongsoo Kwon, M.D., 2910 St. Marys Ave., Hannibal 63401, has become a member of Marion-Ralls-Shelby County Medical Society. Dr. Kwon is a native of Korea, received his preliminary education at Kyungpook National University and his M.D. degree at Kyungpook National University in 1959. He specializes in general surgery.

Mansoor G. Naini, M.D., 24th and Cherry, Kansas City 64108, has become a member of Jackson County Medical Society. Dr. Naini is a native of Iran, received his preliminary education at the University of Esfahan and his M.D. degree at the University of Esfahan in 1965. He specializes in internal medicine.

Michael C. Perry, M.D., 807 Stadium, Columbia 65201, has become a member of Boone County Medical Society. Dr. Perry is a native of Michigan, received his preliminary education at Wayne State University and his M.D. degree at Wayne State University in 1970. He specializes in hematology and medical oncology.

Harold J. Pryor, M.D., Meyer and Prospect, Kansas City 64132, has become a member of Jackson County Medical Society. Dr. Pryor is a native of Jefferson City, received his preliminary education at the University of Missouri and his M.D. degree at the University of Missouri in 1969. He specializes in physical medicine and rehabilitation.

Aswath N. Rao, M.D., 6500 Chippewa, St. Louis 63109, has become a member of St. Louis Medical Society. Dr. Rao is a native of India, received his preliminary education at First Grade College and his M.D. degree at the University of Mysore Medical College in 1959. He specializes in orthopedics.

Thomas F. Reardon, M.D., 1310 S. Grand Blvd., St. Louis, has become a member of St. Louis County Medical Society. Dr. Reardon is a native of St. Louis, received his preliminary education at Rockhurst College and his M.D. degree at St. Louis University in 1965. He specializes in internal medicine.

Bernardo R. Rodrigo, M.D., 915 Leslie B d., Jefferson City, has become a member of Cole C unty Medical Society. Dr. Rodrigo is a native o he Philippines, received his preliminary educatio at Far Eastern University and his M.D. degree at a Eastern University in 1963. He specializes in a esthesiology.

William J. Ross, M.D., 500 S. Kingshighway St Louis, has become a member of St. Louis Co ty Medical Society. Dr. Ross is a native of Ft. Wa ie Ind., received his preliminary education at M University and his M.D. degree at Washin University in 1972. He specializes in pediatri

Albert F. Ruehl, M.D., 1325 S. Grand Blvd. St Louis, has become a member of St. Louis Me a Society. Dr. Ruehl is a native of Missouri, rece his preliminary education at Washington Un rsity and his M.D. degree at St. Louis Universit in 1973. He specializes in otolaryngology.

David J. Schreiber, M.D., 1221 S. Grand B d. St. Louis 63104, has become a member of St. L uis County Medical Society. Dr. Schreiber is a na ve of New Jersey, received his preliminary educa at Albright College and his M.D. degree at Al r Einstein College in 1969. He specializes in urology.

John E. Scott, M.D., 10901 Winner Rd., Inde-pendence, has become a member of Jackson Cou Medical Society. Dr. Scott is a native of Watero Ia., received his preliminary education at the Uni-versity of Iowa and his M.D. degree at the Uni-versity of Iowa in 1968. He specializes in radiol

Philo Shien-Chan Su, M.D., 1431 Southwest B l. Jefferson City 65101, has become a member of (County Medical Society. Dr. Su is a native Japan, received his preliminary education at Ka-siung Medical College and his M.D. degree Kaohsiung Medical College in 1966. He special in obstetrics and gynecology.

Donald Silver, M.D., 807 Stadium, Colun a 65201, has become a member of Boone Cou Medical Society. Dr. Silver is a native of New Y received his preliminary education at Duke Uni-versity and his M.D. degree at Duke Universit in 1955. He specializes in general and thoracic surg

Robert W. Smith, M.D., 1515 Lafayette, St. L s 63104, has become a member of St. Louis Med l Society. Dr. Smith is a native of Ohio, received preliminary education at Kent State University

s M.D. degree at St. Louis University in 1971.
e is a resident in radiology.

Emasue Snow, M.D., 440 S. Market, Springfield,
s become a member of Greene County Medical
ciety. Dr. Snow is a native of Springfield, re-
ived her preliminary education at the University
Missouri and her M.D. degree at Tulane Uni-
rsity in 1950. She specializes in psychiatry.

Wuthisak Soonattrakul, M.D., 919 S. Jefferson,
nnett 63857, has become a member of Dunklin
unty Medical Society. Dr. Soonattrakul is a na-
e of Thailand, received his preliminary education
Mahidol University and his M.D. degree at the
iversity of Chiengmai in 1966. He specializes in
ternal medicine.

Dennis J. Stanczyk, M.D., 1325 S. Grand Blvd.,
. Louis, has become a member of St. Louis Med-
l Society. Dr. Stanczyk is a native of Illinois, re-
ived his preliminary education at St. Procopius
d his M.D. degree at St. Louis University in
68. He specializes in urology.

Larry K. Stauffer, M.D., 700 W. High, Jefferson
ty 65101, has become a member of Cole County
edical Society. Dr. Stauffer is a native of Jefferson
ty, received his preliminary education at West-
nster College and his M.D. degree at Kansas
iversity Medical Center in 1969. He specializes
ophthalmology.

Leslie L. Strangle, III, M.D., 711 Grand, Hanni-
l 63401, has become a member of Marion-Ralls-
elby County Medical Society. Dr. Strangle is a
tive of Texas, received his preliminary education
Southwestern University and his M.D. degree
the University of Texas Southwestern Medical
hool in 1970. He specializes in otolaryngology.

Gracy Thomas, M.D., 2601 N. Whittier, St.
uis, has become a member of St. Louis Medical
ciety. Dr. Thomas is a native of India, received
r preliminary education at MarIvanios College
d her M.D. degree at Kottayam Medical Col-
ge in 1971. She specializes in radiology.

Terrance A. Tyrrell, M.D., 1515 Lafayette, St.
uis 63104, has become a member of St. Louis
edical Society. Dr. Tyrrell is a native of Illinois,
ceived his preliminary education at St. Louis Uni-
rsity and his M.D. degree at St. Louis University
1973. He specializes in radiology.

Robert J. Valko, M.D., Barnes Hospital Plaza,
Louis, has become a member of St. Louis Medical Society. Dr. Valko is a native of Illinois, received his preliminary education at the University of Illinois and his M.D. degree at the University of Illinois in 1968. He specializes in psychiatry.

Curt M. Vogel, M.D., 3707 Woodridge Ct., Columbia 65201, has become a member of Boone County Medical Society. Dr. Vogel is a native of Odessa, received his preliminary education at the University of Missouri and his M.D. degree at the University of Tennessee in 1967. He specializes in general surgery.

Allan R. Weide, M.D., 2700 Hospital Dr., Kansas City, has become a member of Clay County Medical Society. Dr. Weide is a native of Horton, Kan., received his preliminary education at Baker University and his M.D. degree at Kansas University in 1968. He specializes in urology.

D. Douglas Westhoff, M.D., 1505 Southwest Blvd., Jefferson City, has become a member of Cole County Medical Society, received his preliminary education at St. Louis University and his M.D. degree at the University of Missouri in 1969. He specializes in internal medicine, oncology and hematology.

Walter R. Williams, M.D., 808 Amolac Dr., St. Louis, has become a member of St. Louis Medical Society. Dr. Williams is a native of Illinois, received his preliminary education at Blackburn College and his M.D. degree at St. Louis University in 1970. He specializes in surgery.

Michael H. Winer, M.D., Barnes Hospital Plaza, St. Louis, has become a member of St. Louis Medical Society. Dr. Winer is a native of Illinois, received his preliminary education at Washington University and his M.D. degree at the University of Illinois in 1968. He specializes in orthopedic surgery.

John W. Yarbro, M.D., University of Missouri, Columbia 65201, has become a member of Boone County Medical Society. Dr. Yarbro is a native of Tennessee, received his preliminary education at the University of Louisville and his M.D. degree at the University of Louisville in 1956. He specializes in oncology and hematology.

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Nov. 14-16	**Second Annual Symposium—Anesthesia for the Geriatric Patient** Dept. of Anesthesiology, Washington U. School of Medicine Marriott Motor Hotel, St. Louis
Nov. 19	**Seminar in Noninvasive Cardiology: Method of Estimating Cardiac Pump Performance** Depts. of Medicine & Radiology, St. Luke's Hospital and Washington U. Continuing Medical Education St. Luke's Hospital, St. Louis
Nov. 21-22	**The Long Weekend: Infectious Diseases and Intensive Pulmonary Care Workshop** MU-KC School of Medicine, K.C. Southwest Clinical Society and the Academy of Health Professions Crown Center Hotel, Kansas City
Nov. 22	**Semiannual Professional Program: Cancer Detection and Early Diagnosis** Ellis Fischel State Cancer Hospital and Cancer Research Center Hilton Inn, Columbia
Dec. 3	**Postgraduate Seminar: Common Gastrointestinal Disorders** The Ed Bixby Institute for Postgraduate Medical Education Research Medical Center, Kansas City
Dec. 4-5	**Annual Clinical Meeting** Kansas City Society of Ophthalmology and Otolaryngology Plaza Inn, Kansas City
Dec. 4-5	**Symposium: Medical Technology** Division of Continuing Medical Education K.U. Medical Center, Kansas City, Kan.
Dec. 8	**City-Wide Radiologic Conference: Cervical Spine Injuries** Mallinckrodt Institute of Radiology Washington U. School of Medicine, St. Louis
Jan. 12	**City-Wide Radiology Conference: New Techniques in Pediatric Radiology** Mallinckrodt Institute of Radiology Washington U. School of Medicine, St. Louis

LEO H. POLLOCK, M.D.

Missouri Medicine in Review

ORTY YEARS AGO

Wendell G. Scott, M.D,. St. Louis, discussed the ethods in use in performing "Gastro-Intestinal ries, Intravenous and Oral Cholecystography" at e Edward Mallinckrodt Institute of Radiology, ashington University School of Medicine.

"The conception of examining the gastro-intesti- l tract by an opaque substance resulted from the illiant work of a then young Boston medical ident, Dr. Walter B. Cannon." (Cannon, W. B.: ie Movements of the Stomach Studied by Means the Roentgen Ray, Am. J. Physiol. 1:359, 1898). ie technic of the gastro-intestinal examination is e result of a number of years of intensive study d labor. The original outline was formulated by r. R. Walter Mills and Dr. Russell D. Carman, ho were colleagues at the Washington Uni- rsity Medical School some 23 years ago. This sociation came to an end when Dr. Carman went the Mayo Clinic in 1913 and Dr. Mills con- ued with Washington University.

The original report in 1923 of a new method for sualizing the gallbladder (cholecystography) by rs. Evarts A. Graham and Warren H. Cole of the epartment of Surgery, introduced a new era in agnostic medicine and gastro-enterology. (Gra- m, E. A. and Cole, W. H.: Roentgenologic Ex- nination of the Gallbladder).

WENTY-FIVE YEARS AGO

Abuses of the British National Health Service t "are evident everywhere and must lead to more d more regulations, tighter enforcement, greater nalities for violation, further limitations on free- m and further deterioration of the quality of edicine." This pessimistic view of the future of edicine in England, "unless the government radically changes its basic attitude toward medicine," is expressed in a report made by a group of American physicians sent to Great Britain by the American Medical Association.

Members of the committee were Dr. Walter B. Martin, Norfolk, Va., a member of the AMA Board of Trustees and a specialist in internal medicine; Dr. George C. Penberthy, Detroit, surgeon; Dr. Heyworth N. Sanford, Chicago, a pediatrician; Dr. Ulrich R. Bryner of Salt Lake City, a general practitioner; and Dr. Carl M. Peterson, Chicago, secretary of the AMA Council on Industrial Health.

Promising results in treating patients for toxic goiter with a new synthetic drug, Tapazol, are reported by two doctors from Wayne University College of Medicine, Detroit. The drug is an antithyroid compound with action 25 times as powerful as propylthiouracil, a compound commonly used in treating overactivity of the thyproid gland, according to Drs. William S. Reveno and Herbert Rosenbaum in the August 19 issue of *The Journal of the American Medical Association.*

TEN YEARS AGO

The Supreme Court has ruled that the various states must readjust their legislative bodies so that the number of representatives and senators within those bodies reflect the "one-man-one-vote" concept. At this writing, efforts to reapportion the House of Representatives of the Missouri General Assembly have bogged down in political controversy, but it is obvious that the task eventually will be accomplished one way or another.

Disposable syringes may contaminate aqueous solutions contained in them. The source of this contamination is the rubber portion of the plunger, according to Mario A. Inchiosa of Harvard Medical School. Writing in the September issue of The American Pharmaceutical Association's *Journal of Pharmaceutical Sciences,* Dr. Inchiosa points out the significance of this contamination in view of the extensive utilization of disposable syringes, not only for administering injections but, also, for transferring solutions and blood in both clinical practice and in the laboratory. Because of prepackaging procedures, solutions may remain in these syringes for a long period of time.

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ontraindications: Patients with known ypersensitivity to the drug.
arnings: Caution patients about possible ombined effects with alcohol and other NS depressants. As with all CNS-acting ugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.
Usual Daily Dosage: Individualize for maximum beneficial effects. *Oral—Adults:* Mild and moderate anxiety and tension, 5 to 10 mg *t.i.d.* or *q.i.d.*; severe states, 20 or 25 mg *t.i.d.* or *q.i.d.* *Geriatric patients:* 5 mg *b.i.d.* to *q.i.d.* (See Precautions.)
Supplied: Librium® (chlordiazepoxide HCl) *Capsules*, 5 mg, 10 mg and 25 mg—bottles of 100 and 500; Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10; Prescription Paks of 50, available singly and in trays of 10. Libritabs® (chlordiazepoxide) *Tablets*, 5 mg, 10 mg and 25 mg—bottles of 100 and 500. With respect to clinical activity, capsules and tablets are indistinguishable.

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FOR THE PATHOGENS

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Appropriate antibacterial therapy: Up to 3 days therapy with Azo Gantrisin 4 to 6 tablets *Stat.*, then 2 tablets *q.i.d.*; then 11 days with Gantrisin (sulfisoxazole) may be considered.

AZO GANTRISIN®

(50 mg phenazopyridine HCl and 0.5 Gm sulfisoxazole)

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Indications: In adults, urinary tract infections complicated by pain (primarily cystitis, pyelitis and pyelonephritis) due to susceptible organisms (usually *E. coli, Klebsiella-Aerobacter, Staphylococcus aureus, Proteus mirabilis*, and, less frequently, *Proteus vulgaris*) in the absence of obstructive uropathy or foreign bodies. *Important Note:* Carefully coordinate *in vitro* sulfonamide sensitivity tests with bacteriologic and clinical response. Add aminobenzoic acid to culture media for patients already taking sulfonamides. Increasing frequency of resistant organisms currently is a limitation of the usefulness of antibacterial agents including the sulfonamides. Blood levels should be measured in patients receiving sulfonamides for serious infections, since there may be wide variations with identical doses; 12 to 15 mg/100 ml is considered optimal for serious infections; 20 mg/100 ml should be the maximum total sulfonamide level, as adverse reactions occur more frequently above this level.

Contraindications: Children below age 12; sulfonamide hypersensitivity; pregnancy at term and during nursing period. Contraindicated in glomerulonephritis, severe hepatitis, uremia, and pyelonephritis of pregnancy with gastrointestinal disturbances, because of phenazopyridine HCl component.

Warnings: Safe use in pregnancy has not been established. Teratogenicity potential has not been thoroughly investigated. Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been reported; clinical signs such as sore throat, fever, pallor, purpura or jaundice may be early indications of serious blood disorders. Complete blood counts and urinalysis with careful microscopic examination should be performed frequently during sulfonamide therapy.

Precautions: Use with caution in patients with impaired renal or hepatic function, severe allergy, bronchial asthma and in glucose-6-phosphate dehydrogenase-deficient individuals. In the latter, hemolysis may occur. Maintain adequate fluid intake to prevent crystalluria and stone formation.

Adverse Reactions: *Blood dyscrasias:* Agranulocytosis, aplastic anemia, thrombocytopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. *Allergic reactions:* Erythema multiforme (Stevens-Johnson syndrome), skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. *Gastrointestinal reactions:* Nausea, emesis, abdominal pains, hepatitis, diarrhea, anorexia, pancreatitis and stomatitis. *C.N.S. reactions:* Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo and insomnia. *Miscellaneous reactions:* Drug fever, chills, toxic nephrosis with oliguria and anuria polyarteritis nodosa and L.E. phenomenon. D to certain chemical similarities with some goit gens, diuretics (acetazolamide and thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter producti diuresis and hypoglycemia. Cross-sensitivity with these agents may exist.

Dosage: Usual adult dosage for acute, painfu phase of urinary tract infections is 4 to 6 table initially, then 2 tablets four times daily for up t 3 days. If pain persists, causes other than inf tion should be sought. After relief of pain has been obtained, continued treatment of the inf tion with Gantrisin (sulfisoxazole) may be con sidered.

Note: Patients should be told that the orange red dye (phenazopyridine HCl) will color the urine soon after ingestion.

How Supplied: Tablets, each containing 0.5 sulfisoxazole and 50 mg phenazopyridine HC —bottles of 100 and 500.

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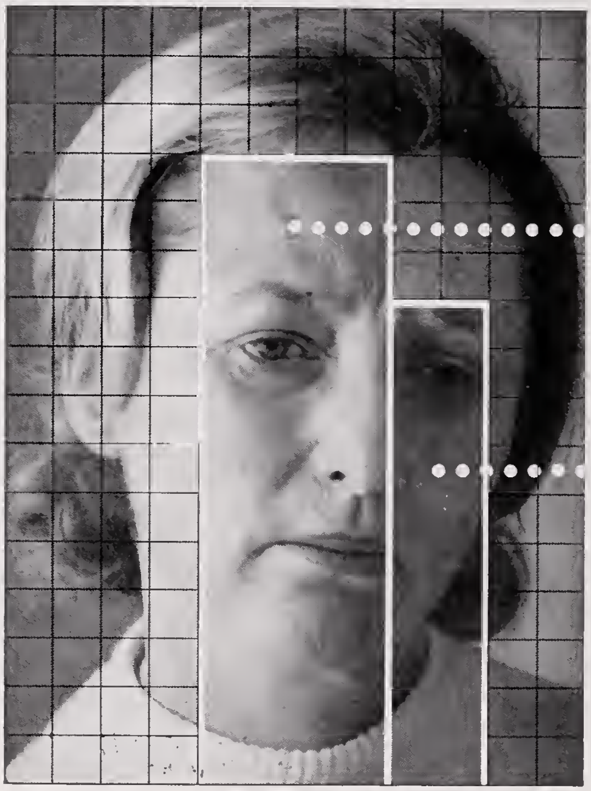
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Associated depressive symptoms

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Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in
and/or severity of grand mal seiz
require increased dosage of stan
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in the patient within a few days rather than in a week or two, although it may take longer in some patients. In addition, Valium (diazepam) is generally well tolerated; as with most CNS-acting agents, caution patients against hazardous occupations requiring complete mental alertness.

Also, because the psychoneurotic patient's symptoms are often intensified at bedtime, Valium can offer an additional benefit. An *h.s.* dose added to the *b.i.d.* or *t.i.d.* treatment regimen can relieve the excessive anxiety and associated depressive symptoms and thus encourage a more restful night's sleep.

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anxiety states
with associated
depressive symptoms

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barbiturates, MAO inhibitors
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Usual precautions indicated in
verely depressed, or with latent
, or with suicidal tendencies.

Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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The MUDRANES

Discreet formulations of four well regarded drugs for the relief of bronchial distress—Potassium Iodide, Glyceryl Guaiacolate, Aminophylline, Ephedrine with Phenobarbital (to lessen cardiac stimulation).

MUDRANE
FIRST CHOICE IN ASTHMA

POTASSIUM IODIDE ..... 195 mg.
AMINOPHYLLINE .. 130 mg.
EPHEDRINE HCl ... 16 mg.
PHENOBARBITAL ... 21 mg.
(May be habit-forming)

MUDRANE-2
NO EPHEDRINE

POTASSIUM IODIDE ..... 195 mg.
AMINOPHYLLINE .. 130 mg.

MUDRANE GG
NO POTASSIUM IODIDE

GLYCERYL GUAIACOLATE .. 100 mg.
AMINOPHYLLINE .. 130 mg.
EPHEDRINE HCl ..... 16 mg.
PHENOBARBITAL .. 21 mg.
(May be habit-forming)

MUDRANE GG-2
NO EPHEDRINE

GLYCERYL GUAIACOLATE ..... 100 mg.
AMINOPHYLLINE .. 130 mg.

MUDRANE GG ELIXIR
PEDIATRIC

Each 5 cc:
GLYCERYL GUAIACOLATE ..... 26 mg.
THEOPHYLLINE ..... 20 mg.
EPHEDRINE HCl ..... 4 mg.
PHENOBARBITAL ... 5.4 mg.
(May be habit-forming)
ALCOHOL V/V 20%

INDICATIONS: For the prompt symptomatic relief of bronchial asthma, emphysema and bronchiectasis. The Mudranes dilate the bronchi and liquefy mucus plugs. DOSAGE: Tablet; One tablet with a full glass of water 3 or 4 times daily as required. Divide tablet for child's dose. Elixir; Children, 1 cc for each 10 lbs. of body weight. May be repeated 3 or 4 times a day. Adult, one tablespoonful 4 times daily. All doses should be followed with a glass of water.

CONTRAINDICATIONS: Aminophylline/Theophylline is contraindicated in the presence of severe cardiac arrhythmias and patients with massive myocardial damage. Ephedrine, in presence of severe heart disease, extreme hypertension, and in hyperthyroidism. Phenobarbital, in porphyria and in patients with known phenobarbital sensitivity. Potassium Iodide, in pregnancy (to protect the fetus against possible iodine-induced depression of thyroid activity), in tuberculosis (produces gumma dissolution), and in acne; also in the presence of known iodide sensitivity. PRECAUTIONS: Aminophylline/Theophylline should be avoided in patients with massive myocardial damage and/or severe cardiac arrhythmias. In children, overdose may cause vomiting, cardiac arrhythmias, and severe agitation. Ephedrine should be used with caution in the presence of severe cardiac disease, particularly arrhythmias and angina pectoris; avoid in hyperthyroidism and severe hypertension. Phenobarbital may be habit-forming. Avoid overdosage. Potassium Iodide: Discontinue in the presence of skin rash, swelling of the eyelids and severe frontal headache. Long use may cause goiter. ADVERSE REACTIONS: Aminophylline/Theophylline may cause nausea, cardiac arrhythmias, and aggravate severe myocardial disease. It may cause headaches and tachycardia. Vomiting and dizziness are not uncommon. Ephedrine: In patients hypersensitive to CNS stimulation, ephedrine may cause nervousness, tachycardia, extrasystole and ventricular arrhythmias. May cause urinary retention, especially in the presence of partial prostatic obstruction. Psychoneurosis may be aggravated. Pre-existing anginal pain will be aggravated. Phenobarbital may produce severe skin rash. Avoid overdosage. May be habit-forming. Potassium Iodide may cause nausea. Over very long period of use, iodides cause goiter. Discontinue if patient develops skin rash, eye irritation, eyelid swelling, or severe frontal headache.

HOW SUPPLIED: Mudrane and Mudrane GG available in bottles of 100 and 1000 tablets; Mudrane-2 and Mudrane GG-2 in 100s; Elixir in pints and half-gallons.

Federal law prohibits dispensing without prescription.

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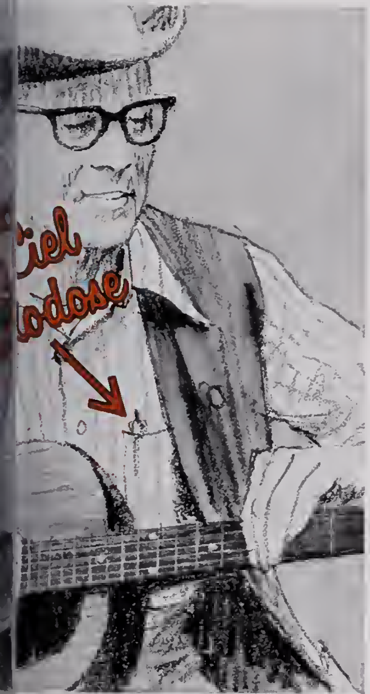
New
Kay Ciel
Solodose

New
Kay Ciel
Solodose



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New KAY CIEL®
(potassium chloride, 1.5g.)
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Each Solodose packet contains:
Potassium Chloride . . . 1.5 g. (20 meq.)
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144-2

When sequential contraception is preferred...

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Ortho-Novum SQ provides good cycle control

provides a low sequential dosage

effective in clinical trials, with a pregnancy rate of 0.43 per 100 woman years

generally well tolerated†

available in the unique DIALPAK* Tablet Dispenser

rtho-Novum SQ

TRADEMARK

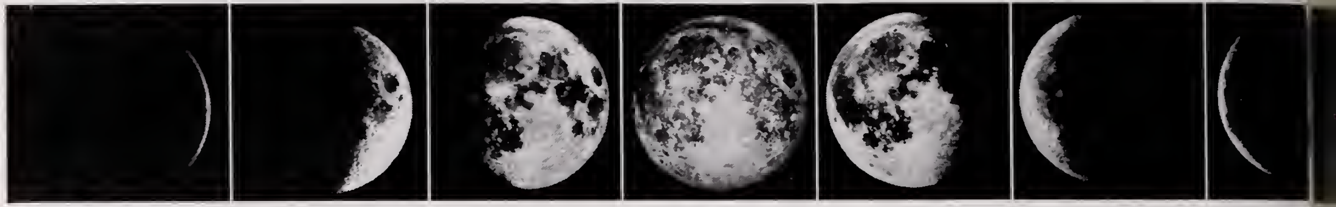
ite tablet contains 0.08 mg mestranol. Each blue tablet contains 2.0 mg norethindrone and 0.08 mg mestranol.

†Serious as well as minor conditions have been reported following the use of oral contraceptives. These conditions include thromboembolic disease. The physician should remain alert to the earliest manifestations of any symptoms of serious disease and discontinue oral contraceptive therapy when appropriate. The physician should be fully aware of the complete Prescribing Information for this product.

See prescribing information on following page.

OJ 622-5

In sequence...



Ortho-Novum SQ Tablets

TRADEMARK

Description: ORTHO-NOVUM SO Tablets provide a sequential oral contraceptive regimen consisting of white tablets containing only mestranol 0 08 mg, and blue tablets containing both mestranol 0 08 mg and norethindrone 2 0 mg.
Action: Gonadotrophin suppression
Special note: Oral contraceptives have been marketed in the United States since 1960. Reported pregnancy rates vary from product to product The effectiveness of the sequential products appears to be somewhat lower than that of the combination products Both types provide almost completely effective contraception

An increased risk of thromboembolic disease associated with the use of hormonal contraceptives has now been shown in studies conducted in both Great Britain and the United States Other risks, such as those of elevated blood pressure and reduced tolerance to carbohydrates, have been reported and appropriate tests should be conducted to monitor these during oral contraceptive therapy Liver disease has also been reported, and the physician should be alert to its earliest manifestations

Long-term administration of both natural and synthetic estrogens in subprimate animal species in multiples of the human dose increases the frequency for some animal carcinomas These data cannot be transposed directly to man The possible carcinogenicity due to the estrogens can neither be affirmed nor refuted at this time Close clinical surveillance of all women taking oral contraceptives must be continued
Indication: Contraception
Contraindications: 1 Thrombophlebitis, thromboembolic disorders, cerebral vascular disease, or a past history of these conditions 2 Markedly impaired liver function 3 Known or suspected carcinoma of the breast. 4 Known or suspected estrogen-dependent neoplasia 5. Undiagnosed abnormal genital bleeding 6 Known or suspected pregnancy
Warnings: 1 The physician should be alert to the earliest manifestations of thrombotic and thromboembolic disorders, thrombophlebitis, cerebrovascular disorders including hemorrhage, pulmonary embolism and retinal thrombosis Should any of these occur or be suspected, the drug should be discontinued immediately

Retrospective studies of morbidity and mortality in Great Britain and studies of morbidity in the United States have shown a statistically significant association between thrombophlebitis, pulmonary embolism and cerebral vascular disease, occlusive or hemorrhagic, and the use of oral contraceptives There have been three principal studies in Great Britain[1-3] leading to these conclusions and three in this country [4-7] The estimate of the relative risk of thromboembolism in the study by Vessey and Doll[3] was about sevenfold, while the United States studies found relative risks of 4 4 to 11, meaning that the users are several times as likely to undergo thromboembolic disease without evident cause as non-users

In May, 1974, the Royal College of General Practitioners in England[8] issued an interim report of its continuing large-scale prospective study comparing a user group to a non-user group This study in its interim analysis states, A statistically significant higher rate of reporting of cerebrovascular accidents in Takers is evident, but the numbers are too small to justify an estimation of the degree of risk " The study also reported a higher incidence of superficial and deep vein thrombosis in users as compared to non-users The risk of superficial and deep vein thrombosis was reported to be lower in women using 50 mcg estrogen preparations

The Sartwell study[4] indicated that the risk did not persist after discontinuation of administration. Both the Sartwell and the Royal College studies indicated that the degree of risk was not associated with duration of treatment

In a collaborative American study[5,6] of cerebrovascular disorders in women with and without predisposing causes, it was estimated that the relative risk of thrombotic stroke was 4 1 to 9 5 times greater in users than in non-users A comparable estimate for hemorrhagic stroke was 2 0

None of the American studies was designed to evaluate a difference between products However, the Sartwell study[4] suggested that there might be an increased risk of thromboembolic disease in users of sequential products

Other retrospective studies[9,10] have reported an increased risk of post-surgery thromboembolic complications in oral contraceptive users. It has been recommended that therapy be discontinued at least one month prior to elective surgery
2 Discontinue oral contraceptive medication if there is gradual or sudden partial or complete loss of vision, proptosis or diplopia, onset or aggravation of migraine or development of headache of a new pattern which is recurrent, persistent or severe, papilledema, or any evidence of retinal vascular lesions.
3 Fetal abnormalities have been reported to occur in the offspring of women who have taken progestogens and/or estrogens during pregnancy [11,12] The safety of ORTHO-NOVUM SO in pregnancy has not been demonstrated Pregnancy should be ruled out before initiating or continuing the contraceptive regimen Pregnancy should always be considered if withdrawal bleeding does not occur
4 A small fraction of the hormonal agents in oral contraceptives has been identified in the milk of mothers receiving these drugs. The long-range effect to the nursing infant cannot be determined at this time.
5. Hepatic lesions (adenomas, hepatomas, hamartomas, regenerating nodules, etc.), occasionally fatal, have been reported in women on oral contraceptives. Such lesions may present as an abdominal mass or with the signs and symptoms of an acute abdomen. These lesions should be considered if the patient has abdominal pain or evidence of intra-abdominal bleeding. This has been reported in short-term as well as long-term users of oral contraceptives.

Precautions: 1. A thorough history and physical examination should be performed be ing oral contraceptives and periodically during their administration and should include ence to breasts and pelvic organs, including Papanicolaou smear since estrogens have to produce tumors, some of them malignant, in five species of subprimate animals 2 E possibly liver function tests may be affected by treatment with ORTHO-NOVUM SO such tests are abnormal in a patient taking ORTHO-NOVUM SO, it is recommended repeated after the drug has been withdrawn for two months 3 Under the influence progestogen preparations, pre-existing uterine fibromyomata may increase in size 4 B agents may cause some degree of fluid retention, conditions which might be influenced such as epilepsy, migraine, asthma, cardiac or renal dysfunction, require careful obse breakthrough bleeding, and in all cases of irregular bleeding per vaginam, nonfunct should be borne in mind. In undiagnosed bleeding per vaginam, adequate diagnostic n indicated 6 Patients with a history of psychic depression should be carefully observed discontinued if the depression recurs to a serious degree. 7 Any possible influence ORTHO-NOVUM SO therapy on pituitary, ovarian, adrenal, hepatic or uterine function a study 8 A decrease in glucose tolerance has been observed in a significant percentag on oral contraceptives The mechanism of this decrease is obscure For this reason, diab should be carefully observed while receiving ORTHO-NOVUM SO therapy 9. The age constitutes no absolute limiting factor, although treatment with ORTHO-NOVUM SO m onset of the climacteric. 10. The pathologist should be advised of ORTHO-NOVUM SO t relevant specimens are submitted. 11. Susceptible women may experience an increa pressure following administration of contraceptive steroids 12. Cholestatic jaundic reported in users of oral contraceptives If this occurs, ORTHO-NOVUM SO should be This condition is more likely to occur in patients who have experienced cholestatic jaun nancy Patients with a history of cholestatic jaundice of pregnancy should be carefully o ing ORTHO-NOVUM SO therapy.
Adverse reactions observed in patients receiving oral contraceptives: A statistical association has been demonstrated between use of oral contraceptives and the follov adverse reactions: thrombophlebitis, pulmonary embolism, cerebral thrombosis and gallbladder disease

Although available evidence is suggestive of an association, such a relationship has confirmed nor refuted for the following serious adverse reactions. neuro-ocular lesions, thrombosis and optic neuritis, hepatic lesions with or without intra-abdominal bleeding.

The following adverse reactions are known to occur in patients receiving oral cor nausea, vomiting, gastrointestinal symptoms (such as abdominal cramps an breakthrough bleeding, spotting, change in menstrual flow, amenorrhea during and aft edema, chloasma or melasma, which may persist, cholestatic jaundice, migraine, ra mental depression, change in weight (increase or decrease), breast changes (tendern ment and secretion), changes in cervical erosion and cervical secretions, suppression when given immediately post-partum, rise in blood pressure in susceptible individuals

Although the following adverse reactions have been reported in users of oral contra association has been neither confirmed nor refuted: anovulation post-treatment, which te more frequently in women with a history of menstrual disorders; premenstrual-like changes in libido; changes in appetite; cystitis-like syndrome; headache, intolerance to ses, nervousness; dizziness, fatigue; backache; hirsutism; loss of scalp hair; erythema erythema nodosum; hemorrhagic eruptions; itching; vaginitis

The following laboratory results may be altered by the use of oral contraceptives hepat increased sulfobromophthalein retention and other tests; coagulation tests—increase in Factors VII, VIII, IX and X, decrease in anti-thrombin III; increase in platelet aggregab function—increase in PBI, and butanol-extractable protein-bound iodine and decrease values; metyrapone test; pregnanediol determination.

References: **1.** Royal College of General Practitioners: Oral Contraception and Throm Disease J Coll Gen Pract *13*:267-279, May 1967. **2.** Inman, W H.W.; Vessey, M.P.: Inve Deaths from Pulmonary, Coronary and Cerebral Thrombosis and Embolism in Women of ing Age, Br Med J 2:193-199, April 27, 1968. **3.** Vessey, M P.; Doll, R Investigation between Use of Oral Contraceptives and Thromboembolic Disease A Further Report 2 651-657, June 14, 1969. **4.** Sartwell, P E.; Masi, A.T.; Arthes, F.G , Greene, G.R.; S Thromboembolism and Oral Contraceptives An Epidemiologic Case-Control Study, Am *90*:365-380, Nov 1969 **5.** Oral Contraception and Increased Risk of Cerebral Ischem bosis, N Engl J Med 288 (17) 871-878, April 26, 1973 **6.** Oral Contraceptives and Strok Women. Associated Risk Factors, J A M.A *231* (7).718-722, Feb 17, 1975 **7.** Oral Con and Venous Thromboembolic Disease, Surgically Confirmed Gall-Bladder Disease, Tumours Report from the Boston Collaborative Drug Surveillance Programme, Lancet: June 23, 1973. **8.** Royal College of General Practitioners: Oral Contraceptives and He May 1974. 9. Vessey, M P.; Doll, R.; Fairbairn, A.S.; Glober, G.: Postoperative Thromb and the Use of Oral Contraceptives, Br Med J *3* 123-126, July 18, 1970 **10.** Greene, G. P E : Oral Contraceptive Use in Patients with Thromboembolism Following Surgery. Infection, Am J Public Health 62(5):680-685, May 1972 **11.** Nora, J J.; Nora, A.H.: Birth Oral Contraceptives, Lancet: 941-942, April 28, 1973. **12.** Janerich, D.T ; Piper, J.M.; Gle Oral Contraceptives and Congenital Limb-Reduction Defects, N Engl J Med *291*(14):697- 1974.

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Raritan, New Jersey 08869

MSMA
NEWS
ROUND - UP
NOVEMBER, 1975

lalpractice crises remedies proposed

Malpractice pamphlets for patients in the mail

MSMA members will soon be receiving copies of a pamphlet designed to explain the malpractice insurance crisis to their patients.

Each member will receive copies of the pamphlet to place in their waiting rooms. If members desire additional free copies, they should contact MSMA Headquarters.

llowing several months of study and consideration, Governor's Task Force on Malpractice has submit- ecommendations for eight legislative remedies for malpractice crisis. Bills encompassing the recom- dations are expected to be pre-introduced in the ouri Legislature this year.

commendations of the Task Force are:

o. 1 — Establish Mandatory Screening Panels

l malpractice suits would be sumitted to a screen- panel composed of health care providers, lawyers, a person and a non-voting judge. If the panel found cient reason for the claimant to proceed in court, claimant would be assisted in gaining expert medi- estimony. If the panel found against the claimant, vould retain the right to sue, but would not be sted by the panel.

he Task Force said that the screening panels would eliminate frivolous cases and increase timely set- ents in legitimate cases, thus reducing costs.

o. 2 — Eliminating Ad Damnum Clause

he Task Force stated that the designation of a ific amount of damages (ad damnum clause) in a ractice action can be harmful in two ways. First, media coverage of this dollar figure is misleading e this amount bears little resemblance to the unt awarded. Second, when an extravagant dollar unt results in publicity, it may place unfounded, rial notoriety upon the defendant.

o. 3 — Require Reporting of Malpractice ms

nding that there was little relevant data relating to ractice in the state, the Task Force called for legis- n to require malpractice insurers to annually re- basic information to the Division of Insurance.

cluded in the report would be data relating to all ns filed, awards, settlements, expenses incurred in nse of claims, profits and other vital information. It d then be easier to determine if premium rates are fied.

he reports would be made available to the state's ical licensing agency so it can monitor the quality re provided by licensees.

o. 4 — Define "Informed Consent"

he lack of clearly defined and accepted criteria for iding the patient's right to be informed of his con- n and of treatments is a cause of confusion and s to many suits, according to the Task Force.

he panel recommended that the law on informed ent be partially codified. This is a statement given he patient consenting to treatment after being ade- ely informed of its need and the risks involved with the procedure in order to make an intellegent decision.

No. 5 — Disclosure of Collateral Source Payments

Under current law, defendants in a malpractice suit cannot introduce evidence that the injured party is receiving compensation from insurance companies and other sources.

The Task Force said that this situation leads to some claimants being over-compensated for losses. Therefore, the panel agreed that the admission of such evidence would allow a redistribution of benefits, thereby affording more adequate and equitable compensation for more victims as well as potentially reducing aggregate insurance loss experience.

No. 6 — Revise Statute of Limitations

The first part of this Task Force recommendation coincides with a proposal by the Missouri Senate Select Committee on Malpractice. This recommendation would change the Statute of Limitations on minors so that children under age six would have until age eight to file suit for malpractice. Claims involving children six years or older would come under the same provisions as adults. That means they would have two years from the act to file suit. Currently, the Statute of Limitations on minors extends two years past their age of majority.

The second part of this recommendation would actually loosen the Statutes somewhat. It provides that when a foreign object is left in the patient's body, that patient would have one year from the time of discovery to bring suit.

No. 7 — Increase Policing Power of State Licensing Board

The Task Force maintained that the reduction of pa-

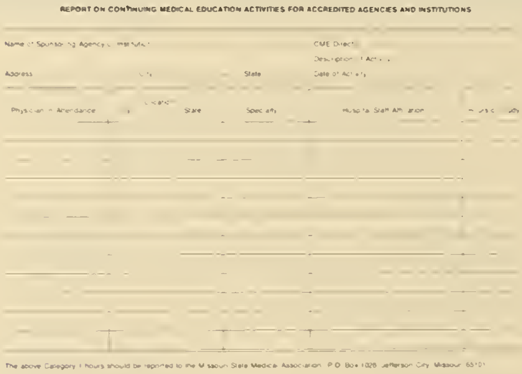
Continued on Next Page

MSMA implementing voluntary CME program

The Missouri State Medical Association, in implementing its voluntary accreditation program for community hospitals and other institutions providing continuing medical education for MSMA members, has developed a mechanism by which the individual physician can record CME activities.

Two devices have been developed by which this process can be accomplished.

Report on Continuing Medical Education Activities of Accredited Agencies and Institutions



REPORT ON CONTINUING MEDICAL EDUCATION ACTIVITIES FOR ACCREDITED AGENCIES AND INSTITUTIONS

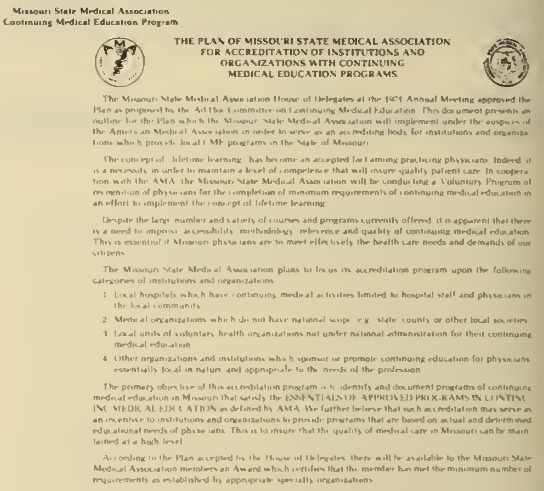
The above Category I hours should be reported to the Missouri State Medical Association, P.O. Box 1028, Jefferson City, Missouri 65101

Once the Missouri State Medical Association provides accreditation to local hospitals, medical organizations, units of voluntary health organizations or other organizations and institutions, it will then be the responsibility of this accredited agency to keep attendance records for those physicians who participate.

Each accredited institution or organization will designate a Director of Medical Education (DME) who will assume responsibility for program implementation. He will be responsible for assisting members of the organization to identify their educational needs, to arrange for programs to meet the needs, assist in evaluation of process and outcome and to stimulate interest in CME.

Each MSMA Councilor District will have an appointed District Continuing Medical Educator Representative (CME). The CME functions as a consultant, a catalyst and a coordinator. When several organizations identify a common need, he tries to promote cooperative efforts to conserve resources. He has district-wide
responsibilities similar to those of the hospital D
The responsibility for accounting for educationa
tivities which are not accredited by MSMA rests
the individual MSMA member. He should be prep
to report these educational activities to MSMA o
annual basis.

Medical Education for AMA's Physician's Recognition Award



Missouri State Medical Association
Continuing Medical Education Program

THE PLAN OF MISSOURI STATE MEDICAL ASSOCIATION
FOR ACCREDITATION OF INSTITUTIONS AND
ORGANIZATIONS WITH CONTINUING
MEDICAL EDUCATION PROGRAMS

The Missouri State Medical Association House of Delegates at the 1971 Annual Meeting approved the Plan as proposed by the Ad Hoc Committee on Continuing Medical Education. This document presents an outline for the Plan which the Missouri State Medical Association will implement under the auspices of the American Medical Association in order to serve as an accrediting body for institutions and organizations which provide local CME programs in the State of Missouri.

The concept of "lifetime learning" has become an accepted fact among practicing physicians. Indeed, it is a necessity in order to maintain a level of competence that will insure quality patient care. In cooperation with the AMA, the Missouri State Medical Association will be conducting a Voluntary Program of recognition of physicians for the completion of minimum requirements of continuing medical education in an effort to implement the concept of lifetime learning.

Despite the large number and variety of courses and programs currently offered, it is apparent that there is a need to improve accessibility, methodology, relevance and quality of continuing medical education. This is essential if Missouri physicians are to meet effectively the health care needs and demands of our citizens.

The Missouri State Medical Association plans to focus its accreditation program upon the following categories of institutions and organizations:

1. Local hospitals which have continuing medical activities limited to hospital staff and physicians in the local community.
2. Medical organizations which do not have national scope, e.g., state, county or other local societies.
3. Local units of voluntary health organizations not under national administration for their continuing medical education.
4. Other organizations and institutions which sponsor or promote continuing education for physicians essentially local in nature and appropriate to the needs of the profession.

The primary objective of this accreditation program is to identify and document programs of continuing medical education in Missouri that satisfy the ESSENTIALS OF APPROVED PROGRAMS IN CONTINUING MEDICAL EDUCATION as defined by AMA. We further believe that such accreditation may serve as an incentive to institutions and organizations to provide programs that are based on actual and determined educational needs of physicians. This is to insure that the quality of medical care in Missouri can be maintained at a high level.

According to the Plan accepted by the House of Delegates, there will be available to the Missouri State Medical Association members an Award which certifies that the member has met the minimum number of requirements as established by appropriate specialty organizations.

A manila folder providing the above informatio
be forwarded to each MSMA member to record
continuing medical education activity in the va
categories as outlined above. A brief explanati
each category is also provided in the folder to assis
physician in identifying his activities.

Each physician will be asked to forward the f
and its contents to the MSMA headquarters o
periodically. Upon receipt, the contents will be reco
to the individual physician and a new folder wi
issued.

Of the six categories identified, 150 hours mini
are required in any three year qualifying period, b
ning in 1976 (hours may be accumulated in any
bination — no specific requirement for each year

The individual that has completed 150 hours of
tinuing medical education will be awarded the P
cian's Recognition Award (PRA). The objectives o
PRA are to recognize and encourage physicians
participate regularly in CME and to stimulate
development of more meaningful CME opportun
for physicians.

Governor's Task Force proposes legislation

Continued

tient injuries is the starting point for remedial action in the malpractice crisis.

Therefore, the Task Force said that attempts to alter either the tort system or the malpractice insurance system should be coupled with reform of the state licensing and disciplinary mechanism. This proposal would give the State Board of Registration for the Healing Arts more power to act against negligent or incompetent doctors.

The Board would be authorized to compel a licensee whose competency is questioned to undergo a "medical competency reexamination" to determine if he or she is fit to continue practice.

No. 8 — Authority to Establish JUA

The Task Force stated that the first seven re
mendations were aimed at improving the malpra
insurance climate in Missouri to guarantee cove
for physicians.

However, since these measures will take tim
become effective, the panel urged that the State I
sion of Insurance be given the authority to establi
Joint Underwriting Association in case the volun
market of insurers withdraws. Participation in
JUA by companies would be a condition of their
tinued authority to write insurance in the state.
Task Force said this authority should be utilized onl
a last resort.

Society representatives stress the importance of informing patients

wide range of problems surfaced for discussion at irst Meeting of Component Medical Society Repre- atives, Oct. 17-18, at the Lake of the Ozarks.

gh on the list, of course, was the current malprac- insurance crisis. Other topics included the struc- and operation of local medical societies, continuing ical education, physician reimbursement and the M.

ring the malpractice discussion, the participants essed their support for the proposed bills drawn up he Missouri Select Committee on Malpractice for oduction next Session.

was stressed that physicians need to inform their ents that the rising cost of insurance will, sooner or , have to be passed on to the patient. Also, the ting participants stated that Missouri physicians to know how they can help pass legislation which ease the crisis.

was emphasized that local medical societies need s on how to increase attendance at local meetings. s also stressed that local societies need to re-define responsibilities and improve communications.

llowing a review of the MSMA's continuing medi- education program, the local society leaders ap- ed the plan and sought ways to obtain wide physi- participation.

rhaps the most poignant statement regarding ician reimbursement was in regard to Medicare: government can set a schedule for paying physi- s fees, but physicians cannot set a schedule due to trust laws."

ter debating the pros and cons of the AMA, the icipants agreed that the dues increase to $250 is ssary and that the AMA is medicine's only hope in teracting the intrusions of government. The AMA, s stated, is undergoing a change for the better and icians should maintain their membership during changeover.

all, 24 physicians participants representing 17 l medical societies took part in the two-day meet-

ug price disclosure hearing set by FTC

blic hearings on the Federal Trade Commission's osed rules to allow disclosure of prescription drug information by retailers to purchasers have been duled.

e hearings will be held in Chicago during the week ecember 1, 1975. The FTC believes that the lack of lability of price information on prescription drugs es consumer to spend more than necessary on s.

e FTC has invited comments on the proposed rules. sicians can write to Mr. Alan E. Krause, FTC onal Office, Room 1437, 55 East Monroe Street, ago, Illinois 60603.

MSMA members urged to pay AMA assessment

To date, more than 75% of Missouri's members in the AMA have paid the special $60 assessment authorized by the House of Delegates last Fall.

The AMA has mailed six notices to active members and five notices to dues exempt members to encourage payment of the assessment.

Nationwide, more than 138,000 AMA members have responded to the plea for the assessment.

Those MSMA members who have not paid the assessment are urged to send their check either directly to the AMA or to MSMA Headquarters.

MSMA resolutions draw HEW comment

"We understand the reason for the concern expressed about obtaining Medicare eligibility information on patients since we are committed to the prompt processing of claims," said a Social Security Administration official in response to a resolution passed by the MSMA House of Delegates.

The resolution called on the government to establish a system whereby the eligibility status of patients could be obtained quickly so the patient would know when his benefits have been exceeded.

Thomas M. Tierney, Director of the Bureau of Health Insurance, SSA, stated that the Medicare history file contains records on over 20 million beneficiaries and that although the file is updated daily, it is physically impossible to have an on-line system to supply the quick response asked in the resolution.

Tierney estimated that inpatient admissions of Medicare beneficiaries would exceed six million annually.

Responses to two other MSMA resolutions were received from William Munier, M.D., Acting Director of the Office of Professional Standards Review in the Department of HEW.

In discussing a resolution calling for the return of PSRO decisions to the "grass roots," Dr. Munier stated that the authority for establishing norms, screening criteria and standards remains in the hands of local PSRO's.

Dr. Munier said that model criteria developed by the AMA and the national medical specialty societies for HEW are only guidelines to assist local PSROs in developing their own criteria.

"PSROs may accept these models in full, in part or reject them entirely as they see fit," said Dr. Munier.

Concerning the MSMA resolution calling for implementation of PSRO in government hospitals on a trial basis before PSRO is put into effect in the private sector, Dr. Munier said that HEW is now implementing PSRO-like review in nine Public Health Service hospitals and has taken steps to incorporate the Indian Health Service facilities into the PSRO program.

"The Department of Defense and the Veterans Administration have been interested in adopting the system for use in their hospitals as well," according to Dr. Munier.

Missouri's statewide candidates elected by minority of voters

Did you realize that Missouri statewide candidates in the 1974 general elections were placed in office by a minority of voters?

Speaking before the Woman's Auxiliary to the Missouri State Medical Association, Dr. John I. Matthews, Chairman of the MSMA Legislative Committee, quoted statistics that only 56.4% of the registered voters in Missouri actually cast ballots in 1974.

Moreover, only 68% of those voters eligible to register were registered. Mathematically, that means that approximately 38% of the eligible voters of Missouri elected our statewide candidates.

Dr. Matthews encouraged the Auxiliary to conduct mini-registration campaigns. A campaign could include such areas as (1) making sure every employee in each physician's office is registered, (2) checking to see that all the doctors, doctor's families and office assistants in a county medical society are registered, and (3) encouraging members of hospital staff to register and vote.

Dr. Matthews also pointed out the importance of personal contact between physicians and their wives with our elected representatives. He said that now, while the lawmakers are between legislative sessions, is the time to get better acquainted with each Representative and Senator. Then, as matters of concern arise during the session, it is easier to discuss the issues with the lawmakers.

VD epidemic spreads to outstate Missouri

"The gonorrhea epidemic is spreading in Missouri, Dr. Herbert R. Domke, director of the Missouri Division of Health, reported. The epidemic increase is occurring in outstate Missouri among white persons and teenagers and females, a shift from the traditional patterns of the past, Domke said. In the past, gonorrhea was predominantly in male patients from the nonwhite population areas of St. Louis and Kansas City.

The numbers of gonorrhea cases reported in males and from the metropolitan centers have increased very little since 1967, compared to the tripling of cases in the state's nonmetro regions and among females and the 146 per cent increase in cases among white Missourians. In addition, gonorrhea in teenagers rose 56 per cent.

Statewide, Missouri reported 16,170 gonorrhea cases in 1974, a rise of 54 per cent over 1967. Domke said increased sexual promiscuity in both males and females apparently is responsible for the upward surge in gonorrhea."

Physicians, hospitals view cancer programs

The AMA and the American Hospital Associati
encouraging members to look at the situation ir
communities with respect to the incidence of car
the thyroid as a possible consequence of the
radiation in the 1930s, 40s and 50s to shrink chil
infected tonsils, adenoids and thymus glands.

In that period, it was acceptable medical practi
physicians to prescribe and administer radiation
frequently in hospital facilities, to treat certain
lems of the neck and face. Recently, however, s
have shown a high correlation between this trea
and cancer, with one study showing a 7% incide
thyroid carcinoma in unselected patients with a h
of irradiation to the neck area. This percentage is
er than would be expected in the general popu
and implies a continuing public health problem.

Thyroid carcinoma is usually very slow growin
poses little immediate danger to life. Neverth
there is a need for hospitals and physicians to
together to educate their own colleagues about p
methods of screening and treating this problem, a
ensure that persons in their communities who ne
tention receive it.

It is necessary that any community or regiona
gram be carefully planned to make certain
guidelines for screening procedures, treatment
release of information are carefully develope
agreed upon by all area providers and that oth
lated groups, such as public health departments,
volved in the planning. A coordinated approac
minimize undue public alarm.

Some approaches that can be applied to situati
the community level:

1. Large scale "call backs" in which hospitals
searched 30 years of medical records and attemp
contact each person who received the treatment,
been tried in some communities. This approach is
and requires continuing efforts due to the difficu
locating such records and the mobility of the Ame
society.

2. Coordinated use of the media should be consi
as an approach. For example, in Milwaukee, the
cal College of Wisconsin, the Milwaukee County
cal Complex, the Wood Veterans Administration H
tal, and volunteer physicians have developed a
gram, and with major assistance from the media
1,400 persons were screened during the first year
screening is free and available to all Milwaukee
residents, even though the Milwaukee Medical C
never administered the treatment. Ten percent of
screened were found to have nodules for which su
was recommended, and 35 percent of that group
found to have a thyroid malignancy.

The AHA and the AMA encourage hospitals
physicians to work together in their communities
regions to develop guidelines and procedures for sc
ing persons who may have received this treatment
to determine the best way to educate the public
seeking screening.

Putting out the fires of arthritic pain

Rheumatoid arthritis can sometimes spread like wildfire, with joint after joint going up inflamed: "The usual onset is manifested by spotty joint involvement but an acute onset of symmetrical polyarthritis may be noted."*

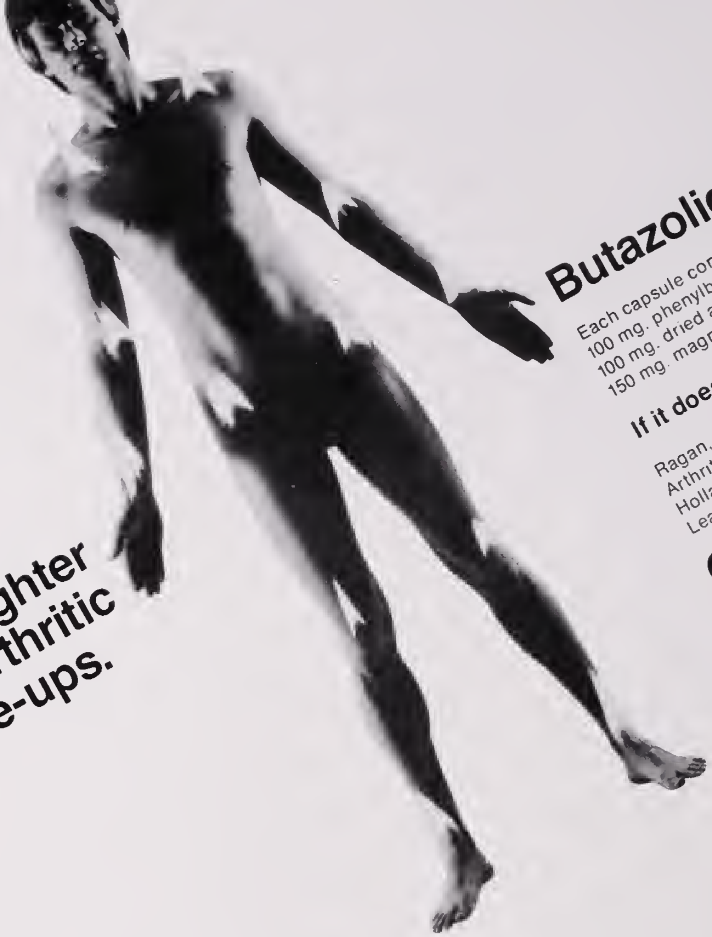
If aspirin fails, consider Butazolidin alka. Giving one capsule four times a day often provides prompt, pain-relieving, anti-inflammatory action to help restore joint mobility. The results you can get within a week can be maintained on as little as one or two capsules daily.

Serious side effects can occur. Select patients carefully (particularly the elderly) and follow them closely in line with the drug's precautions, warnings, contraindications and adverse reactions. For full details, please read the prescribing information. It's summarized on the back of this page.

Butazolidin® alka

Each capsule contains:
100 mg. phenylbutazone USP
100 mg. dried aluminum hydroxide gel USP
150 mg. magnesium trisilicate USP

If it doesn't work in a week, forget it.



Fire fighter for arthritic flare-ups.

Butazolidin® alka

Each capsule contains:
100 mg. phenylbutazone USP
100 mg. dried aluminum hydroxide gel USP
150 mg. magnesium trisilicate USP

If it doesn't work in a week, forget it.

Ragan, C.: The Clinical Picture of Rheumatoid Arthritis, in Arthritis, ed. 8, edited by J. L. Hollander and D. J. McCarty, Jr., Philadelphia. Lea & Febiger, 1972, chap. 21, p. 335.

Geigy

Important Note: This drug is not a simple analgesic. Do not administer casually. Carefully evaluate patients before starting treatment and keep them under close supervision. Obtain a detailed history, and complete physical and laboratory examination (complete hemogram, urinalysis, etc.) before prescribing and at frequent intervals thereafter. Carefully select patients, avoiding those responsive to routine measures, contraindicated patients or those who cannot be observed frequently. Warn patients not to exceed recommended dosage. Short-term relief of severe symptoms with the smallest possible dosage is the goal of therapy. Dosage should be taken with meals or a full glass of milk. Substitute alka capsules for tablets if dyspeptic symptoms occur. Patients should discontinue the drug and report immediately any sign of: fever, sore throat, oral lesions (symptoms of blood dyscrasia); dyspepsia, epigastric pain, symptoms of anemia, black or tarry stools or other evidence of intestinal ulceration or hemorrhage, skin reactions, significant weight gain or edema. A one-week trial period is adequate. Discontinue in the absence of a favorable response. Restrict treatment periods to one week in patients over sixty.
Indications: Rheumatoid arthritis, osteoarthritis, bursitis, acute gouty arthritis and rheumatoid spondylitis.
Contraindications: Children 14 years or less, senile patients; history or symptoms of G.I. inflammation or ulceration including severe, recurrent or persistent dyspepsia, history or presence of drug allergy; blood dyscrasias; renal, hepatic or cardiac dysfunction, hypertension, thyroid disease; systemic edema; stomatitis and salivary gland enlargement due to the drug; polymyalgia rheumatica and temporal arteritis, patients receiving other potent chemotherapeutic agents, or long-term anticoagulant therapy.
Warnings: Age, weight, dosage, duration of therapy, existance of concomitant diseases, and concurrent potent chemotherapy affect incidence of toxic reactions. Carefully instruct and observe the individual patient, especially the aging (forty years and over) who have increased susceptibility to the toxicity of the drug. Use lowest effective dosage. Weigh initially unpredictable benefits against potential risk of severe, even fatal, reactions. The disease condition itself is unaltered by the drug. Use with caution in first trimester of pregnancy and in nursing mothers. Drug may appear in cord blood and breast milk. Serious, even fatal, blood dyscrasias, including aplastic anemia, may occur suddenly despite regular hemograms, and may become manifest days or weeks after cessation of drug. Any significant change in total white count, relative decrease in granulocytes, appearance of immature forms, or fall in hematocrit should signal immediate cessation of therapy and complete hematologic investigation. Unexplained bleeding involving CNS, adrenals, and G.I. tract has occurred. The drug may potentiate action of insulin, sulfonylurea, and sulfonamide-type agents. Carefully observe patients taking these agents. Nontoxic and toxic goiters and myxedema have been reported (the drug reduces iodine uptake by the thyroid). Blurred vision can be a significant toxic symptom worthy of a complete ophthalmological examination. Swelling of ankles or face in patients under sixty may be prevented by reducing dosage. If edema occurs in patients over sixty, discontinue drug.
Precautions: The following should be accomplished at regular intervals: Careful detailed history for disease being treated and detection of earliest signs of adverse reactions; complete physical examination including check of patient's weight, complete weekly (especially for the aging) or an every two week blood check, pertinent laboratory studies. Caution patients about participating in activity requiring alertness and coordination, as driving a car, etc. Cases of leukemia have been reported in patients with a history of short- and long-term therapy. The majority of these patients were over forty. Remember that arthritic-type pains can be the presenting symptom of leukemia.
Adverse Reactions: This is a potent drug; its misuse can lead to serious results. Review detailed information before beginning therapy. Ulcerative esophagitis, acute and reactivated gastric and duodenal ulcer with perforation and hemorrhage, ulceration and perforation of large bowel, occult G.I. bleeding with anemia, gastritis, epigastric pain, hematemesis, dyspepsia, nausea, vomiting and diarrhea, abdominal distention, agranulocytosis, aplastic anemia, hemolytic anemia, anemia due to blood loss including occult G.I. bleeding, thrombocytopenia, pancytopenia, leukemia, leukopenia, bone marrow depression, sodium and chloride retention, water retention and edema, plasma dilution, respiratory alkalosis, metabolic acidosis, fatal and nonfatal hepatitis (cholestasis may or may not be prominent), petechiae, purpura without thrombocytopenia, toxic pruritus, erythema nodosum, erythema multiforme, Stevens-Johnson syndrome, Lyell's syndrome (toxic necrotizing epidermolysis), exfoliative dermatitis, serum sickness, hypersensitivity angiitis (polyarteritis), anaphylactic shock, urticaria, arthralgia, fever, rashes (all allergic reactions require prompt and permanent withdrawal of the drug), proteinuria, hematuria, oliguria, anuria, renal failure with azotemia, glomerulonephritis, acute tubular necrosis, nephrotic syndrome, bilateral renal cortical necrosis, renal stones, ureteral obstruction with uric acid crystals due to uricosuric action of drug, impaired renal function, cardiac decompensation, hypertension, pericarditis, diffuse interstitial myocarditis with muscle necrosis, perivascular granulomata, aggravation of temporal arteritis in patients with polymyalgia rheumatica, optic neuritis, blurred vision, retinal hemorrhage, toxic amblyopia, retinal detachment, hearing loss, hyperglycemia, thyroid hyperplasia, toxic goiter, association of hyperthyroidism and hypothyroidism (causal relationship not established), agitation, confusional states, lethargy, CNS reactions associated with overdosage, including convulsions, euphoria, psychosis, depression, headaches, hallucinations, giddiness, vertigo, coma, hyperventilation, insomnia, ulcerative stomatitis, salivary gland enlargement.
(B)98-146-070-J (10/71)

For complete details, including dosage, please see full prescribing information.

GEIGY Pharmaceuticals
Division of CIBA-GEIGY Corporation
Ardsley, New York 10502

BU 10259

DYAZIDE®

Trademark

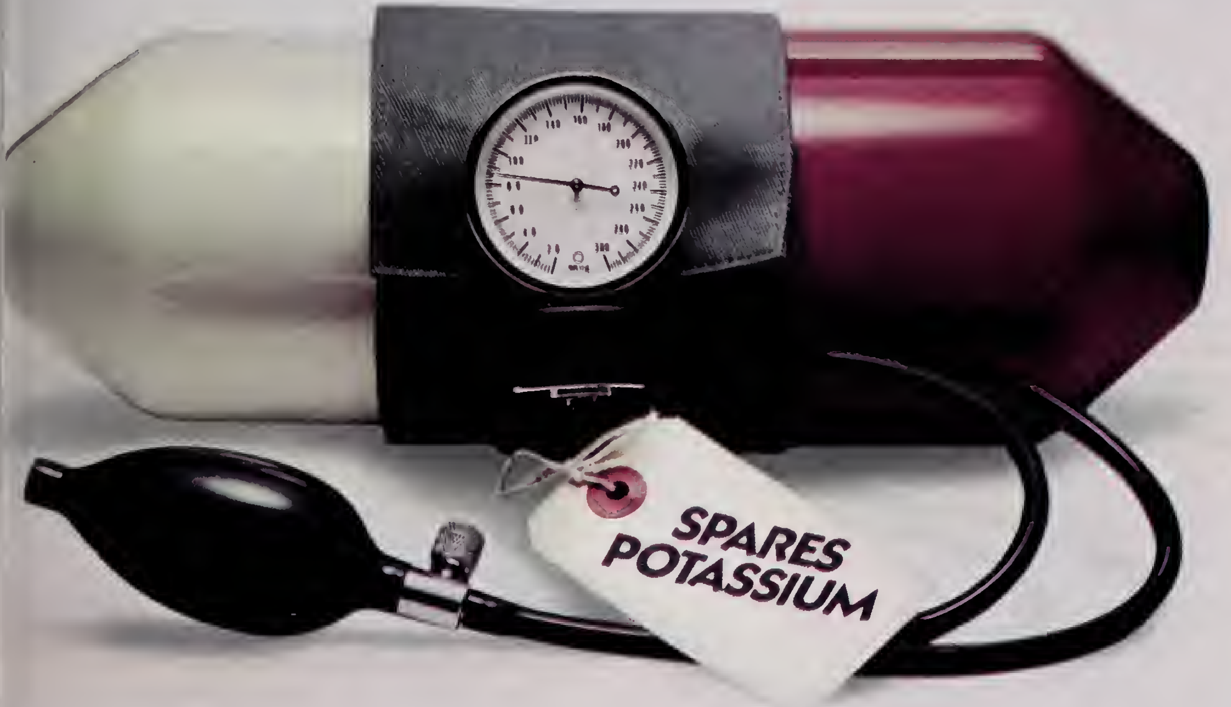
Each capsule contains 50 mg.
of Dyrenium® (triamterene, SK&F)
and 25 mg. of hydrochlorothiazide.

MAKES SENSE

RIAMTERENE CONSERVES POTASSIUM VHILE HYDROCHLOROTHIAZIDE OWERS BLOOD PRESSURE

OR LONG-TERM CONTROL F HYPERTENSION*

Serum K+ and BUN should be checked periodically. (See Warnings Section.)



fore prescribing, see complete prescribing in-
mation in SK&F literature or *PDR*. The fol-
ving is a brief summary.

Varning
'his fixed combination drug is not indi-
ated for initial therapy of edema or hyper-
ension. Edema or hypertension requires
herapy titrated to the individual patient. If
he fixed combination represents the dosage
o determined, its use may be more convenient
n patient management. The treatment of
ypertension and edema is not static, but
nust be reevaluated as conditions in each
atient warrant.

lications: *Edema:* That associated with con-
stive heart failure, cirrhosis of the liver, the
phrotic syndrome; steroid-induced and idio-
thic edema; edema resistant to other diuretic
rapy. *Mild to moderate hypertension:* Useful-
ss of the triamterene component is limited to
potassium-sparing effect.

ntraindications: Pre-existing elevated serum
tassium. Hypersensitivity to either component.
ntinued use in progressive renal or hepatic
sfunction or developing hyperkalemia.

**arnings: Do not use dietary potassium supple-
nts or potassium salts unless hypokalemia
velops or dietary potassium intake is markedly
paired.** Enteric-coated potassium salts may
use small bowel stenosis with or without
eration. Hyperkalemia (>5.4 mEq/L) has been reported in 4% of patients under 60 years, in 12% of patients over 60 years, and in less than 8% of patients overall. Rarely, cases have been associated with cardiac irregularities. Accordingly, **check serum potassium during therapy, particularly in patients with suspected or confirmed renal insufficiency (e.g., elderly or diabetics). If hyperkalemia develops, substitute a thiazide alone. If spironolactone is used concomitantly with 'Dyazide', check serum potassium frequently**—both can cause potassium retention and sometimes hyperkalemia. Two deaths have been reported in patients on such combined therapy (in one, recommended dosage was exceeded; in the other, serum electrolytes were not properly monitored). Observe patients on 'Dyazide' regularly for possible blood dyscrasias, liver damage or other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving Dyrenium (triamterene, SK&F). Rarely, leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with the thiazides. Watch for signs of impending coma in acutely ill cirrhotics. Thiazides are reported to cross the placental barrier and appear in breast milk. This may result in fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly other adverse reactions that have occurred in the adult. When used during pregnancy or in women who might bear children, weigh potential benefits against possible hazards to fetus.

Precautions: Do periodic serum electrolyte and BUN determinations. Do periodic hematologic studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in post-sympathectomy patients. The following may occur: hyperuricemia and gout, reversible nitrogen retention, decreasing alkali reserve with possible metabolic acidosis, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), digitalis intoxication (in hypokalemia). Use cautiously in surgical patients. Concomitant use with antihypertensive agents may result in an additive hypotensive effect. 'Dyazide' interferes with fluorescent measurement of quinidine.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis; rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting (may indicate electrolyte imbalance), diarrhea, constipation, other gastrointestinal disturbances. Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and, rarely, allergic pneumonitis have occurred with thiazides alone.

Supplied: Bottles of 100 capsules; in Single Unit Packages of 100 (intended for institutional use only).

SK&F Co., Carolina, P.R. 00630
Subsidiary of SmithKline Corporation

AMA's Clinical Convention Flies to Hawaii

In addition to postgraduate courses, timely medical subjects will be offered each day in state-of-the-art lectures and sympo

Advance Registration

AMA Clinical Convention
HONOLULU, HAWAII
November 30–December 5

SCIENTIFIC COURSES

Monday-Wednesday, Dec. 1-3/7:30-9:00 AM (4½ hour, 3-day course: $45)

1. Dermatology for Non-Dermatologists
2. Evaluation of the Unconscious Patient
3. Hyperlipidemia
4. Infectious Diseases in Children
5. Management of Adolescent Problems
6. Newer Antibiotics
7. Newer Concepts of Family Planning
8. Office Management of Sexual Difficulties
9. Peripheral Vascular Disease—Diagnosis and Treatment
10. Pulmonary Function Tests and Blood Gases

Monday-Wednesday, Dec. 1-3 (Numbers 1-10)
1st Choice #____; 2nd Choice #____; 3rd Choice #____

Monday-Wednesday, Dec. 1-3/10:30 AM-Noon (4½ hour, 3-day course: $45)

11. Acid-Base, Fluid and Electrolyte Balance
12. Advanced Electrocardiography
13. Critical Patients—Critical Decisions
14. Normal and Abnormal Uterine Bleeding
15. Office Management of Anorectal Disorders
16. Office Practice of Gynecology
17. Physicians' Marriages
18. Special Problems of Child Abuse
19. Surgical Lesions of the Intestines—Diagnosis and Treatment
20. Treatment of Common Pediatric Allergies

Monday-Wednesday, Dec. 1-3 (Numbers 11-20)
1st Choice #____; 2nd Choice #____; 3rd Choice #____

Thursday-Friday, Dec. 4-5/7:30-10:30 AM (6 hours for total course; 3 hours on Thursday, 3 hours on Friday: $60)

21. Acid-Base, Fluid and Electrolyte Balance (repeat)
22. Basic Electrocardiography
23. Birth Defects and Clinical Genetics
24. Dermatology for Non-Dermatologists (repeat)
25. Fetal Monitoring
26. Ophthalmoscopy for the Non-Ophthalmologist
27. Pediatric Cardiology
28. Pitfalls of Emergency Room X-Rays
29. Office Endocrinology
30. Immunology—1976
31. The Uterine Pap Smear

Thursday-Friday, Dec. 4-5 (Numbers 21-31)
1st Choice #____; 2nd Choice #____; 3rd Choice #____

Offered Both Monday & Tuesday, Dec. 1 & 2/7:30 AM-Noon (4½-hour course: $45)

32. Basic Life Support—Cardiopulmonary Resuscitation (Dec. 1) ________
33. Basic Life Support—Cardiopulmonary Resuscitation (Dec. 2) ________

Wednesday-Friday, Dec. 3-5/9:00 AM-Noon (9-hour course: $90)

34. Advanced Life Support—Cardiopulmonary Resuscit tion. (Prerequisite: Basic Life Support Cours (Dec. 3-5) ________

Courses of the AMA Committee on the Medical Aspec of Sports (Each a 3-hour course: $30)

Monday, Dec. 1/7:30-9:00 AM & 10:30-Noon
35. The Physical Exam ________

Tuesday, Dec. 2/7:30-9:00 AM & 10:30-Noon
36. The Oriental Arts (Karate, Judo, Yoga) ________

Wednesday, Dec. 3/7:30-9:00 AM & 10:30-Noon
37. Emergency Care on the Field ________

Thursday, Dec. 4/7:30-10:30 AM
38. Wrestling ________
39. Aquatic Sports ________

Friday, Dec. 5/7:30-10:30 AM
40. Rehabilitation ________

Tuesday-Wednesday, Dec. 2-3/7:30-10:30 AM (6 hours for total course; 3 hours on Tuesday, 3 hours on Wednesday: $60)
41. Writing for Scientific Journals ________

LUNCHEON ROUND TABLES

(Held in Hilton Hawaiian Village Long House Room, luncheon round tables are jointly sponsored by the AMA Auxiliary and AMA Council on Scientific Assembly. Cost: $10.00 each.)

Tuesday, December 2 (12:15-1:45 PM) • Topic—Ancient Polynesian Medicine ________

Thursday, December 4 (12:15-1:45 PM) • Topic—Delhi Belly, Gyppy-Tummy, and Other Diseases of Travelers ________

General Registration

_____Non-member physicians: $35
_____Guests of non-members: $10
_____Foreign M.D.'s: no fee
_____AMA members and their guests: no fee
_____Medical students, interns and residents: no fee

My remittance of $_____ is enclosed. Make check or money order payable to the American Medical Association. Payment must accompany registration.

Please print

Name________________________
(Each physician must register in his own name)

Office Address________________________

City/State/Zip________________________

I am a member of the AMA through the following State Medical Association or government service____________

Office Phone No.________________________

☐ Send travel information; or call toll-free to: (800) 621-1046, except in Alaska and Hawaii; in Illinois call (312) 782-3462

Return this form today to AMA's Dept. of Membership Statistics, 535 N. Dearborn St., Chicago, IL 60610

The Council Reports

Meeting of Sept. 13, 1975

oward J. McAlhany, M.D., Springfield, Chairman, called th meeting to order. Those present were Drs. McAlhany; R llen Chandler, Kansas City; Max S. Franklin, St. Louis; o I. Matthews, Jefferson City; Richard V. Bradley, St. Lis; James C. Cope, Columbia; John N. Martin, St. Jo- e; J. Russell Comer, Hannibal; Donald R. Judd, St. Lis; Louis P. Hetlage, Troy; Robert E. Bregant, Jefferson Ci; William D. Bradshaw, Clinton; Andrew McCanse, Ksas City; Claude W. Cooper, Thayer; E. T. Hansbrough, Pcar Bluff; Stanley S. Peterson, Springfield; Rae W. Froe- id Lebanon; Hubert A. Ritter, St. Louis; J. Loren Wash- on, Versailles; James T. Brown, Springfield; George Lady- m, Poplar Bluff; Joseph B. White, Charles Lobeck, Jr. an William C. Allen, Columbia; Richardson K. Noback, Ksas City; Herbert R. Domke, Jefferson City; David Chal- or and George Thoma, St. Louis; R. A. Slickman, Kansas C; Mrs. William R. McPhee, Kansas City; Mrs. George P. Vilson, Columbia; Messrs. J. R. Johnston, Hollister S. rh and William Lindsley, St. Louis; Allen D. Smith, Kan- a City; Gary L. Schnedler, Springfield; and Messrs. Ray Mntyre, Royal O. Cooper, C. C. Swarens, Ron Ellison and D Wilson, Staff.

APPROVAL OF COUNCIL MINUTES

r. McAlhany opened the meeting by calling for approval of he minutes of the Council Meeting held on May 31, 9. On motion, duly seconded, these minutes were ap- r ed as printed.

REPORT OF THE EXECUTIVE SECRETARY

r. McIntyre reported that several meetings have been e n the areas designated as Health Service Areas (HSAs) ur the National Health Planning and Resources Develop- nt Act of 1974. He indicated that physicians should be itly interested and stated that meetings have been set for Spngfield, Flat River and Sedalia with one to be held in Mshall on September 11.

r. McIntyre indicated to the Council that their folders oained a copy of the new abortion reporting form used y he Missouri Division of Health (for their information).

.D. Day at the University of Missouri-Columbia will be n the weekend of November 14-15. The scientific pro- r will be sponsored by the University Medical Center llay Friday and Saturday morning. The football game be- wn Oklahoma and Missouri will be held on Saturday ftnoon.

REPORT OF THE TREASURER

. Bradley, MSMA Treasurer, gave an itemized Treasur- r' Report as of August 31, 1975, indicating the receipts, disrsements, etc. and stating that our budget is presently n od shape.

MSMI

r. Royal O. Cooper was asked to give a status report on M II and introduce the representative from HBE Leasing Coration.

r. Cooper introduced Mr. J. R. Johnston, HBE Leasing Coration, St. Louis, Missouri. Mr. Johnston said that the M. II is studying the possibility of making available to the M IA membership an equipment leasing program through H Leasing Corporation and explained the program, stat- ng hat HBE Leasing Corporation has nearly 20 years of experience in medical equipment leasing. Mr. Johnston explained the type of trifold mailing piece along with a letter that they would anticipate sending to the membership. This brochure spells out background information on the company, the advantages of leasing equipment, how the program works, etc. A reply card will be attached.

It was pointed out that there would be no cash outlay as far as MSMA is concerned on production of materials, mailing, etc. This expense will be borne by the leasing company.

Motion was made, seconded and carried that the leasing program proposal as outlined to the Council be endorsed.

Mr. Cooper reported that since the MSMI's inception in April of this year, it has generated $570,000 in premium income for 261 policies. He stated that the class mix is very good—Class I—130; Class II—12; Class III—74; Class IV—18; Class V—7; Class VI—20. He stated that the brochures explaining the insurance program are very attractive and most of them have been sent. Mr. Cooper gave the Council brief information regarding the market surveillance on malpractice insurance.

Because the MSMI is a for-profit corporation, it was proposed that MSMI sponsor the tours for MSMA and this was so approved. Mr. Cooper indicated that there was a brochure in the Council folder on Manila which would be a February, 1976 trip.

SENATE SELECT COMMITTEE ON MALPRACTICE

Mr. Cooper reported that we are very pleased with the attendance and publicity for the Missouri State Senate Select Committee on Malpractice hearings. Hearings have been held in several parts of the state with one scheduled for next week in Cape Girardeau, St. Louis in October and Mid-Missouri in November with the idea that the final polished accepted bills can be pre-filed in December. He said that some of the problems were lack of insurance, defensive medicine, older physicians retiring, etc. Mr. Cooper indicated that the Senate Select Committee has spent two to three days a month on medical malpractice. They have presented drafts of proposed legislation which they will refine and prefile. Some of the provisions in the drafts call for the following:

1. A ceiling of $500,000 on the total amount recoverable.
2. Fees of plaintiff's attorney would not exceed 33⅓% of any amount awarded. This may be changed to a sliding scale arrangement later.
3. Statute of Limitations on minors would be changed. They would come under the regular "two years from the date of the alleged act" statute except that a minor under the age of six shall have until his eighth birthday in which to file.
4. The establishment of medical malpractice review boards in each Congressional District of the state. Hearings would be held by a Circuit Court judge appointed by the Chief Justice of the Supreme Court. The hearing would be informal, except the Board would prepare a formal statement of its recommendations which would be admissible as evidence. A tax on professional liability carriers would fund the operation. The makeup of the Board will be studied further.

After brief discussion regarding the proposed legislation on malpractice, motion was made, seconded and carried that the Council commend the Senate Select Committee for its efforts on our behalf and support in principle the legislation drafted for introduction into the General Assembly.

Chairman McAlhany stated that at this time he had a pleasant task to perform and presented Dr. J. Loren Washburn with a plaque indicating the Association's appreciation for his contributions to organized medicine in his many roles with the Association, particularly as Alternate Delegate and, later, Delegate to the AMA.

Dr. Stanley Peterson then presented Dr. Washburn with a collage depicting some of the events that took place at various AMA meetings during Dr. Washburn's tenure.

Dr. Washburn thanked the Council and Officers for their words of gratitude and indicated that he would cherish the plaque and collage forever.

REPORT OF AMA DELEGATES

Dr. Peterson gave a brief summary of the AMA Annual Meeting held in Atlantic City. He stated that he felt this meeting seemed to represent more grass roots opinion than ever before. Of the eight Delegates and Alternates from Missouri, six were present at the meeting and worked very hard.

The AMA dues were raised to $250, which is needed, he said, if we are going to be spokesman for organized medicine. Dr. Max H. Parrott was installed as AMA President and Dr. Richard E. Palmer, as President-Elect.

There was some discussion at the AMA regarding elimination of some of the elected offices; a budget was adopted that should balance; and they voted to form a re-insurance company. At this point, Dr. Peterson invited the Council and Officers to Springfield on September 29, during Dr. Malcolm Todd's visit. Dr. Todd is Immediate Past-President of the AMA.

In other actions, the AMA delegates applauded the Board's action on the suit against HEW regarding post-admission certification of hospital patients. The House authorized the Board to set subscription rates for many of its publications and endorsed a study to restructure the AMA. The House adopted the Missouri resolution regarding PRISM. Newly elected delegates may begin their terms on January 1 or on July 1. The House urged constituent societies to provide full membership privileges for medical students at nominal dues. The House supported the Board in opposing the implementation of the National Health Planning and Resources Development Act enacted by Congress. At this point, Dr. Peterson recommended that physicians go to the local HSA meetings and take an active part.

The policy adopted at the 1974 Annual Convention regarding PSRO's was reaffirmed. Many other things were accomplished at the meeting and it was a good meeting. Dr. Peterson indicated that he feels the AMA is a strong organization, but they do need the help and support of every physician.

REPORT OF THE WOMAN'S AUXILIARY

Mrs. McPhee, President of the MSMA Woman's Auxiliary, introduced Mrs. George P. (Sue) Wilson, President-Elect.

Mrs. McPhee reported that the immunization program which the Auxiliary spearheaded, along with MSMA and the Division of Health, seemed to be quite successful. Orders have come in for 191,000 pieces of immunization material and she thanked Dr. Domke and the Division of Health for their great assistance in this program.

At the Annual Convention, the Auxiliary plans to have a space set aside for a silent auction of items donated by physicians and their wives. She asked the physicians if they had a particular talent, painting, etc. please share it with the Auxiliary.

The Auxiliary is holding its Fall Conference in Sedal on October 22-23.

Mrs. McPhee reported that their national organizatio as changed its name to the American Medical Association x-iliary.

Dr. Domke then thanked the Woman's Auxiliary for efforts regarding the immunization program.

On motion, duly seconded, the report of the Wo Auxiliary was accepted with commendation.

On motion, duly seconded, it was agreed that the Co of MSMA should convey to the Board of the Woman's iliary their thanks and recognition of the great assist that the Woman's Auxiliary has given to the MSMA.

AD HOC COMMITTEE—118TH ANNUAL SESSION

George H. Ladyman, M.D., Chairman of the Ad Committee—118th Annual Session, reported there wi 29 scientific sessions at the 1976 Annual Meeting. year this number is larger. It was recommended that re be a maximum of six sessions running concurrently with ve being preferred. Rep. Paul Rogers (R.-Fla.) has been n-tacted regarding speaking at the General Session. We looking forward to a good session in Kansas City.

CONTINUING MEDICAL EDUCATION

Dr. Ladyman reported that in March of 1975, the Co on Medical Education of the AMA approved the Miss ri State Medical Association's Continuing Medical Educa n accreditation program. This enables the Committee on tinuing Medical Education to carry out surveys of ong programs of continuing medical education within the of Missouri. He further reported that the AMA has appr d the 1975 MSMA's Annual Session for Category I credit r the scientific sessions it provides the state's physicians. ginning this year, the AMA Physician's Recognition Av d recipients will find the MSMA's seal attached to the aw This award is given to those physicians who have com ed 150 hours of continuing medical education activities.

Dr. Ladyman reported that a good response has been ceived from the hospitals; 15 to 20 hospitals have aske s to look at their programs. A site visit will be conducte n September 26 in Poplar Bluff. He said that in Miss there are not many CME programs that are not directly sociated with either a private, community or county pital. By the first of 1976, it is hoped that six to ten ins tions will have been made. At that time, we hope that e hospital and each physician will have been provided a CME folder and each quarter the CME hours can be corded and tallied. We must determine a way to review information every three months and send the award w they have completed the requirements. This is the status the CME program at the present time.

Dr. Hetlage stated that at one of the AMA leaders conferences at one session, members of the audience w able to talk directly to the AMA Board of Trustees. He w dered if the Council might be interested in doing someth like this at the MSMA Annual Meeting.

Discussion regarding the location of the next several nual Sessions followed and it was pointed out that a decis should be made regarding the 1977 Annual Session. St fer's Riverfront Inn in St. Louis does have the facilit However, for the first time, they will be charging for me ing rooms. Dr. Ladyman pointed out, however, that th booth rental charge seemed to be quite a bit less and wo offset the meeting room charge.

Mr. McIntyre then indicated that Tan-Tar-A at the La of the Ozarks is becoming quite a convention center a that we have inspected their facilities. They are in a po tion to handle our convention if we wish to try a third lo tion.

n motion, duly seconded, and carried, it was agreed that th 1977 Annual Session be held at Stouffer's in St. Louis; ar 1978 at Tan-Tar-A with the stipulation that the Council nt at Tan-Tar-A at the earliest possible time to study the fa ities there. The 1976 Annual Session is already sched- ul for Kansas City.

he question was raised as to whether there is a need for in nterim meeting of the MSMA House of Delegates. Dr. L yman indicated that this might be helpful for a more ve leadership.

r. Matthews suggested that having an opportunity to sit n and ask the AMA delegates various questions should part of every annual session.

COUNCILOR DISTRICT REPORTS

istrict #1—Dr. Martin reported that he had attended h AMA-AHA National Conference on Professional Liabili- y Most of the states were represented and all have most of h same problems regarding malpractice. Some of the items l ussed were limitation on damages; limitation on contin- y fee; quality of care assurance; elimination of incompe- e physicians; immunity for peer review activities; dupli- on of payments; periodic payments instead of lump sum; o l witness law—a lot of so-called expert witnesses make h a business. These are some of the things each state h ld have.

istrict #2—Dr. Comer reported that he has been able o et around to visit most of the physicians in his area. He e ntly attended the CMMR County Medical Society meet- n and, also, the HSA meeting in Marshall. The HSA meet- n seemed to be dominated by CHP and RMP and physi- i representation was sparse.

istrict #3—Dr. Judd reported that the summertime in i listrict was very quiet and he had no particular report.

istrict #4—Dr. Hetlage reported that his Fourth Coun- il District representatives met on September 10 and dis- ued the following items:

egarding the disposition of a resolution on Patient Edu- a onal Programs which was passed by the House of Dele- s in April, Dr. Hetlage suggested that communication e rding this policy he made to hospital staff organizations, n ddition to county medical societies. It was felt that it not be proper for the MSMA to communicate directly o ospital staff organizations, but his district did feel the ncil should discuss this.

r. Hetlage indicated that a broad discussion of the rela- hip of the MSMA to the malpractice problem in Mis- o i was held. After much discussion of the benefits and h tcomings of the current MSMI program and a discussion f enate Bill #458 passed by the last Legislature, the fol- o ng resolution was proposed. Dr. Hetlage presented the e lution and moved its acceptance. The motion was sec- r ed and carried.

> HEREAS, The physicians of Missouri are beset by innumerable ems concerning malpractice and, particularly, the cost of medi- al ability insurance, and
> HEREAS, There is a recognized need to provide lower cost cal liability insurance to the entire membership of MSMA; and
> HEREAS, Senate Bill #458 passed by the 78th General Assem- f the Missouri State Legislature provides the means to create f-owned mutual insurance company to provide cooperative low nedical liability to all its members; therefore, be it
> *solved*, That an Ad Hoc Committee of Council be formed to tigate the means and provide the framework for a mutual insur- company to be wholly owned and funded by the doctors of uri and to move with all due haste in this endeavor so that a plan may be presented to the MSMA House of Delegates for approval at the meeting in April, 1976.

he Fourth District members discussed individual prac- ic associations. Legislation passed by the federal govern- t encourages the formation of these organizations. The th District proposed that the Council of the MSMA a the lead in forming a group for the discussion of the principle throughout the state, so that sufficient information is available to each physician in order that action may be taken if and when it is necessary.

Dr. Hetlage said that the remainder of his report would be covered in other items on the agenda.

District #6—Dr. Bradshaw indicated that because he had been out of his office for some time, he had no report. He said that proposed legislation has been drafted for means of developing more rural physicians for Missouri and he will bring this back to the Council for their further study.

District #7—Dr. McCanse reported that the physician turnout at the Kansas City meeting of the Senate Select Committee was quite good.

TEL-MED, a telephone question-answer type arrangement in Jackson County began in February and as of August, 48,941 calls have been received.

A federal grant application has been made in excess of $800,000 to get an HMO in Kansas City. The same group had received a previous grant for planning services, so there is still activity in this area at this time.

District #9—Dr. Cooper reported that in his own area, there is increasing interest in national health insurance, PSRO, Malpractice insurance, etc. He said that his area is in need of more physicians. He mentioned the death of Dr. B. J. (Jack) Bass who was active in MSMA matters over many years.

District #10—Dr. Hansbrough indicated that the Senate Select Committee on Malpractice is coming to Cape Girardeau next Friday and the physicians in his area are well informed regarding this. It has been a quiet summer in District #10.

District #8—Dr. McAlhany reported that the Governor's Task Force on Malpractice had several meetings. He is a member of this Task Force. The Task Force is made up of

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severe anemia, congestive heart failure, or a history
pendence or suicidal tendencies. May impair
and coordination with increased accident risk.

ADVERSE REACTIONS: Drowsiness, fatigue, vertigo, incoordination, tremor, muscle weakness, ataxia, hypotension, respiratory depression, delirium and coma. Dryness of nose, mouth, and throat, pupillary dilatation or blurred vision, urinary retention, abdominal pain, nausea, vomiting, diarrhea, and hypersensitivity reactions. Overdose may result in hallucinations, excitement, ataxia, incoordination, athetosis, convulsions, and death.

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15 members, but only one M.D. and one D.O. The Task Force has approved two pieces of legislation to be pre-filed in December: (1) Elimination of the "ad damnum" clause and (2) statewide review panel which would be set up similar to that proposed by the Senate Select Committee. Under this panel, all cases would have to be reviewed before they could go to court.

The Task Force also is considering the following three items and possibly may recommend legislation on these: (1) Define Informed Consent; (2) Modify Collateral Source Rule; (3) Contingency fee be placed on graduated basis.

Dr. McAlhany stated that he felt that a definition of medical malpractice is needed in Missouri. He stated that, hopefully, the Task Force would recommend that every claim filed must be reported to the Insurance Commissioner and the Commissioner would make an annual report to the General Assembly.

Dr. McAlhany was asked if he felt that the Task Force and the Senate Select Committee would make a joint effort at proposing legislation. He stated that he doubted that this would be feasible. The Task Force probably will introduce its legislation into the House and the Senate Select Committee's legislation will be introduced into the Senate and then a compromise agreement will be worked out.

Dr. McAlhany reported that Dr. Malcolm Todd, Immediate Past-President of the AMA, will be in Springfield on September 29 and 30 and asked Mr. Schnedler to give a brief rundown on the visit. Mr. Schnedler outlined the various activities of Dr. Todd while he is in Springfield. There will be a dinner meeting held on the evening of the 29th. Mr. Schnedler indicated that the Council members also would be receiving invitations to this dinner.

WHITE HOUSE CONFERENCE

Dr. Cope reported that he had attended the White House "Town Meeting" Conference held on the previous day in St. Louis. He felt that this was a great meeting. Dr. Cope stated that he had had lunch with David Mathews, the new Secretary of HEW.

STATE CONFERENCE ON HEALTH SERVICE AREAS

Mr. C. C. Swarens reported that a Statewide Conference on Health Service Areas had been held in Jefferson City on August 19. He stated that the real purpose of this meeting in Jefferson City was to add impetus to the local areas to get moving in setting up Health Service Agencies in each area.

Dr. Bradshaw asked if there is any chance that any of the boundaries for the areas in Missouri could be changed. Dr. Domke stated that the Governor had designated the areas. It seems, however, that the Governor is dissatisfied with the law and the program under it.

Mr. Swarens stated that a meeting of component medical society officers will be held on October 17 and 18. Letters have gone out to the Presidents and Secretaries of County Medical Societies.

COMMITTEE ON ARRANGEMENTS

Dr. McAlhany appointed the following members to serve on the Committee on Arrangements for the 1976 Annual Session: Dr. Andrew McCanse, Kansas City, Chairman; Dr. John Martin, St. Joseph and Dr. William Bradshaw, Clinton.

LEGISLATIVE REPORT

Dr. Matthews pointed out that the four proposed bills coming out of the hearings by the Senate Select Committee on Malpractice had already been approved in principle by the Council.

Dr. Matthews stated that it would be well to have a committee appointed by the President of the Association to work with the Osteopathic Association on legislation other areas of mutual interest. Motion was made, secon and carried that such a committee be appointed.

A bill that will be introduced by the podiatrists was ferred to Legal Counsel for consideration as to what changes in wording would mean.

Dr. Matthews stated that due to the current malprac situation and other legislative activities, it was necessar find a way to get wider dissemination of what is being d on the legislative level.

Dr. Matthews moved that a special meeting be set up tween the MSMA Executive Secretary and the execu secretaries of the county medical societies to develop an novative way to get information down to physicians. Mot was seconded and carried.

GOVERNOR'S TASK FORCE ON CERTIFICATE OF NEED

Dr. Hubert Ritter gave a preliminary report on the G ernor's Task Force on Certificate of Need, of which he i member. He stated that the Task Force will be studying following three areas: (1) Hospital construction; (2) H pital remodeling; (3) Purchasing of equipment.

Dr. McAlhany asked Dr. Ritter to give the Council other report on this Task Force at the December meeting.

REMARKS OF MEDICAL SCHOOL DEANS

Dr. McAlhany introduced Dr. David R. Challoner, new Dean of St. Louis University Medical School.

Dr. Challoner stated that, as yet, he did not have the d on the newly enrolled class. The Learning Resources Cen is now under construction and Dr. Challoner also outlin several other construction projects now underway.

Dr. Challoner indicated that he felt everyone should aware of the Federal Health Manpower legislation curren going into hearings in the U. S. Senate as this legislati could directly affect funding for medical students and t academic curriculum process of the schools.

Dr. Noback stated that the new class of 72 students Kansas City are all virtually from Missouri. The class about evenly divided between metropolitan and rural are Dr. Noback reported that most of the graduates from school are in primary care residencies and most of these a in the Kansas City region. The Kansas City Medical Sch has been adding new faculty members in the area of t basic sciences; Dr. Noback stated that construction on t Truman Medical Center is moving on schedule and it shou be ready in about a year.

Dr. White introduced Dr. Charles C. Lobeck, Jr., the ne Dean of the University of Missouri-Columbia School Medicine. Dr. White reported that 110 students had recen ly entered the medical school and they were about even divided between metropolitan and rural areas. The fami medicine program at the University has increased the num ber of residencies to 24 with an utlimate goal of 30.

Dr. White stated that several months ago, the Universi had been invited by the National Center for Health Servic Research to make an application to establish a Center f Health Services Research. Two of the six centers in t U. S. would be designated as National Resources. He repor ed that an application had been submitted and that the Un versity was still competitive at this time.

Dr. White stated that he would like to report on the cu rent status of the attempt to establish a comprehensive ca cer center within the state. Several years ago the State Ca cer Hospital, Cancer Research Center, the University an other medical schools in the state had individually submitte applications to become the comprehensive cancer center fo the state. None of these applications were successful, an it was suggested that, perhaps, these various institution

(Continued on page 666)

WASHINGTON

he American Medical Association brought the cerns of American medicine to the attention of Congress a number of times during the season he Harvest Moon.

t a hearing before a House Judiciary Subcom- ntee looking into the charge that federal agencies be taking too much power into their own ds, the AMA testified that "although potentially erent in many agencies, abuses have become e obvious in the health agencies during the past years."

aymond T. Holden, M.D., Chairman of the A Board of Trustees, said the many health pro- ns Congress approved during this time "because he complexity of the solutions inherent, were n mere skeletons. In its haste to provide opera- al programs, Congress often has allowed execu- agencies and bureaus to add the flesh."

s a result, Dr. Holden said, the final program n is "unrecognizable" from what Congress had nind. He charged there has been intentional non- formance with Congress's intent, "an insatiable etite for more regulation" in which the bureauc- "runs amok by attempting to regulate any ac- y which touches upon, influences, or is affected the Congressional program." The time is long rdue to put a stop to regulatory abuse, the AMA ial told the Subcommittee.

r. Holden pointed to the Health, Education and fare Department's actions on Utilization Re- v. After withdrawing the initial proposal for pital pre-admission certification, strongly op- ed by the AMA, the Department went ahead final rules that were "equally objectionable" equiring review of all patients within 24 hours. Holden said provisions of the basic Medicare were "improperly invoked" and irrelevant pro- ons of other programs were "imperiously used" HEW. The AMA brought suit and was success- in obtaining a preliminary injunction upheld on eal.

dgar T. Beddingfield, M.D., Vice-Chairman of AMA's Council on Legislation, told the Sub- mittee that the AMA is backing a measure to nd the Administrative Procedures Act to re- e agencies to follow certain procedures. The introduced by Rep. Thomas Kindness (R.-Ohio), calls for adequate time for comment and expands the type of governmental actions that would come under the rule-making regulations. The bill (HR 10301) requires the agency to include "the rationale in accepting, rejecting or accepting in modified form the comments received by the interested parties."

Dr. Beddingfield said this is to "assure that the agency not indulge further in its practice, often utilized, of rejecting out-of-hand comments with which it does not agree. . . ." Any final rule substantially changed from its proposed form would have to go through the process as a proposed rule to allow comment, he said.

* * *

The AMA told Congress it is time to improve the health of Indians.

Robert B. Hunter, M.D., a member of the AMA Board of Trustees, said the Indian Health Service "has done well with what it has, but it does not have enough." Dr. Hunter, testifying before the House Subcommittee on Indian Affairs, endorsed legislation before the House and Senate to improve health services for Indians.

In the past, increases in the budget for Indian health services have done little more than keep up with inflation, the physician told the lawmakers. "They have enabled the Service to maintain its health care system, but not to improve it," Dr. Hunter noted.

Based on extensive studies by the AMA and others, Dr. Hunter said, one solution to the manpower needs must be to attract more Indians to the health professions. He supported provisions in the measures to train more Indian physicians through scholarships and in other ways.

Changes were recommended to allow employment of private health professionals on a contract basis to meet backlogs in health care services needed by Indians. An immediate construction and modernization program for health facilities was endorsed as well as provisions requiring Indian participation in planning and program operation.

He urged passage of a provision for a one-year study to investigate alcoholism and mental health among Indians.

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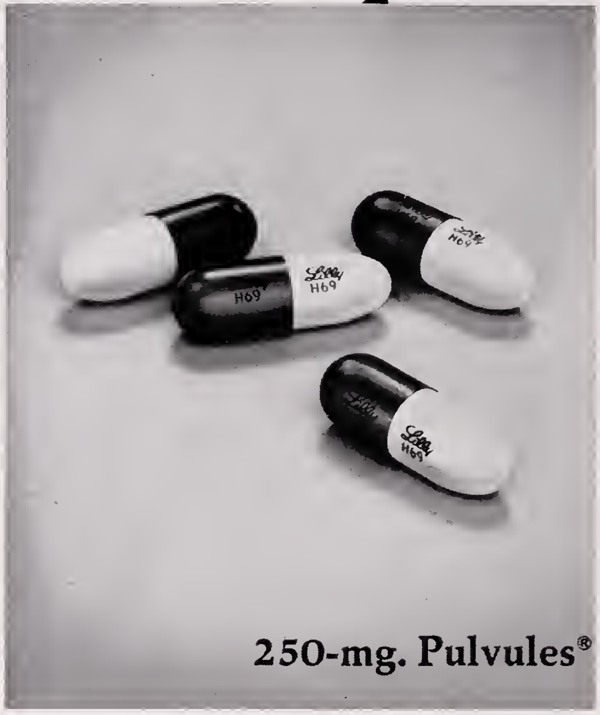
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USHA MEHRA, M.D., HERBERT B. TAYLOR, M.D.
and **DENIS CAVANAGH, M.D.,** *St. Louis*

Comparison of Colposcopy-Directed Biopsies And Cold-Knife Conization

TE USE OF COLPOSCOPY was first described by Hiselmann in Germany in 1925, and he is considerd the father of colposcopy. His idea was that n ts earliest form, cancer of the cervix must occu as minute ulcers or tumors which could be recogized by the gynecologist given adequate illuminion.

Colposcopy is in widespread use today in Europe a in some Latin American countries. It is gain- in popularity in the United States. The delay n ts adoption in this country has been due mainly t he effectiveness of the cytologic screening progms. For many years, colposcopy and cytologic sceening were considered to be competitive metho. Now, however, it is clear that they supplement eh other and that a combination of the two r hods will improve diagnostic accuracy.

Colposcopy is a clinical diagnostic method, and cologic screening is a laboratory method. So far, t use of colposcopy in this country has been lagely limited to major teaching hospitals and cacer centers.

The average gynecologist in this area feels that wen a patient has abnormal cytologic findings a no obvious cervical carcinoma, the safest way o rule out invasive carcinoma is by cone biopsy a fractional curettage. Certainly, it is so when a killed colposcopist is not available. In order to d ide upon whether we could safely substitute colposcopy directed biopsy for diagnostic cone biopsy at the St. Louis University Hospital, the present study was undertaken.

Materials and Methods

A colposcopic examination was performed on 52 consecutive patients during the period from 1972 to 1974. All patients had abnormal cytologic findings, including persistent cytologic class II smears and all Papanicolaou smears class III, IV and V. Trichomonad vaginitis and other infections were treated before patients were included in the study. In each case, a routine vaginal speculum ex-

Fifty patients with abnormal cytologic findings were evaluated by colposcopy-directed biopsies and endocervical curettage. They then were subjected to cold conization and fractional curettage. The colposcopy-directed biopsies gave the diagnosis in 92% of the cases. No cases of carcinoma in situ or invasive carcinoma were missed. Three patients were pregnant and conization was done after 37 weeks of gestation. Two patients had invasive carcinoma and conization was unnecessary. The authors are from the departments of Gynecology-Obstetrics and Pathology, St. Louis University School of Medicine.

TABLE 1

Histopathologic Diagnosis on Colposcopy Directed Punch Biopsy		*Histopathologic Diagnosis on Cold Knife Conization*	
Chronic cervicitis	14	Chronic cervicitis	8
		Mild dysplasia	1
		Moderate dysplasia	4
		Severe dysplasia	1
Mild dysplasia	12	Mild dysplasia	5
		Moderate dysplasia	3
		Severe dysplasia	1
		Chronic cervicitis	3
Moderate dysplasia	11	Moderate dysplasia	6
		Severe dysplasia	2
		Chronic cervicitis	1
		Mild dysplasia	2
Severe dysplasia	10	Severe dysplasia	5
		Chronic cervicitis	3
		Mild dysplasia	1
		Moderate dysplasia	1
Carcinoma in situ	3	Carcinoma in situ	2
		Moderate dysplasia	1
	50		50
Invasive carcinoma	2	Invasive carcinoma no conization	2

amination was performed. The cervix was examined with the colposcope without cleaning, and the findings were noted. A solution of 3% acetic acid was then used to clear the mucus and bring out any abnormal lesions. The cervix was then reexamined. Any visible abnormal areas were biopsied under colposcopy. A Schiller's test was performed only if no abnormality could be detected by colposcopy. Next, the endocervical canal was ins cted with an endocervical speculum.

TABLE 2

HISTOPATHOLOGIC DIAGNOSIS ON ENDOCERVICAL CURETTAGE

Endocervical Curettage

(1) No pathologic diagnosis	13
(2) Cervicitis	5
(3) Proliferative phase	2
(4) Secretory phase	1
(5) Mild dysplasia	1
(6) Moderate dysplasia	1
(7) Severe dysplasia	2
(8) Atypical cell	1
(9) Insufficiency of tissue for diagnosis	5
Total	31

Endocervical curettage was performed in 3 patients in conjunction with spot biopsy. All pat were submitted to fractional curettage and knife conization if the colposcopy-directed bi revealed less than invasive carcinoma.

Results and Analysis

Fifty-two patients were examined under co copy and punch biopsies. Two patients showe vasive carcinoma (Stage IB), so cold knife co tion was omitted. Instead, patients were treate radical hysterectomy and bilateral pelvic lyr adenectomy. The remaining 50 patients were mitted to cold knife conization (Table 1). T ty-six patients (52%) showed a colposcopy-dire biopsy diagnosis in complete agreement with obtained on the cone biopsy specimen. In 12 tients (24%), the directed biopsy had a higher r ing compared with the cold cone biopsy, an patients (24%) had a directed diagnosis of a l degree than that obtained on the cone biopsy sp men.

When considering the missing of severe dys sia as being serious, the accuracy was 92% and case of carcinoma in situ or invasive carcin was missed. Two of the three patients who carcinoma in situ were pregnant, and the diag tic conization was done after 37 weeks gestatio each case.

Endocervical curettage was performed on 31 casions (Table 2). In three patients, severe dys sia was found in these curettings, and all t cases showed severe dysplasia of the ectocer One patient had moderate dysplasia in the en cervical canal but showed only mild dysplasia the ectocervix.

In view of these findings, (1) we suggest tha is unusual to have a higher reading on endocervi curettage than on the ectocervix and, indeed, if the endocervical curettage has a higher read compared to the directed cervical biopsy, coni tion is necessary.

Comment

It has been established by various authors[1-11] t a combination of cytologic screening and colp copy has improved our accuracy in the detecti of cervical neoplasia. Cytologic screening and c poscopy each have an accuracy of 80% to 8 When both methods are used in one patient, th neoplasia will be detected in 97.5% to 99.3%.[12-15]

/alker and Baden[16] reported on a series of 47 rgnant patients with abnormal colposcopic find- n. Only ten of their patients had cone biopsies formed, and these were monitored by cytologic ening and colposcopy. Although cold-knife zation is the most accurate method for diag- ng serious cervical disease during pregnancy, resents some technical difficulties. The cervix atulous, distorted and highly vascular during gnancy. Also, it is frequently dilated and ef- d by the 37th week of gestation, so adequate zation is very rarely achieved especially in late gnancy. It also is potentially dangerous because he possibility of such complications as hemor- ge, infection, premature labor, cervical incom- nce, cervical stenosis, chorioamnionitis and cer- l laceration at the time of delivery. In our s, all three pregnant patients had a histopatho- c diagnosis on directed biopsy which was in ement with that obtained on the cone biopsy imens.

ownsend *et al*[8] reported on 50 patients who endocervical curettage and colposcopic spot sies. He concluded that the colposcopic biop- were reliable if the endocervix was free of ase. In our studies, patients had endocervical ttage and none had significantly abnormal ings without abnormal colposcopic spot biop-

afl and Mattingly[17] presented a series of 1,206 s with abnormal cytologic findings. Only 5.6% heir patients required cone biopsies, because egative colposcopy or unsatisfactory colpos- . Eighty-nine patients were pregnant, and cone sy was avoided in all of these patients.

conclusion, it seems apparent from our study from a review of the literature that the aver- gynecologist, given an adequate number of ents to study, can learn to use a colposcope fully and so eliminate the need for cold knife zation in most of his patients. Once the tech- e is mastered, it is neither tedious nor time uming. However, cytologic screening will re- the primary method of cervical cancer screen- Colposcopy is a supplement to cytology, rather a substitute for it.

ecific indications for colposcopic examination re the instrument and one skilled in its use are lable are as follows:

) Abnormal Papanicolaou smear (Class III, IV, and V).
) Persistent "abnormal benign" cytologic findings (Papanicolaou Class II).
(3) Evaluation of a patient whose mother took DES during the pregnancy of which she is the product.
(4) The appearance of a grossly abnormal cervix in the absence of obvious carcinoma.
(5) Patients with symptoms referable to the cervix (for example, contact bleeding or abnormal discharge) in the absence of a gross lesion.

The combination of cytologic screening and colposcopy has improved the detection rate with regard to abnormalities of the cervix from the 80%-to-85% range to the 85%-to-95% range. As more gynecologists become skillful and confident in the use of the colposcope, the number of cold conizations being performed will drop by 85% to 95%. Cone biopsy is a more formidable operation than is generally appreciated, with a significant complication rate.[18] Our findings in this study support the view that once colposcopy is mastered, cone biopsy can be limited to the following indications:

(1) The patient with abnormal cytologic findings but with no colposcopically visible target lesion.
(2) The presence of a lesion which on colposcopic examination is seen to be extending into the cervical canal.
(3) Abnormal findings on endocervical curettage short of invasive carcinoma.
(4) The therapeutic conization for the treatment of carcinoma in situ of the cervix in a patient who does not want to have a hysterectomy.

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THOMAS CRITCHLOW, M.D., *Columbi*
JEAN-R. DUPONT, M.D., *Sik*

Gangrene of the Small Bowel Following Aorto-Femoral Bypass

Case Report

Infarction of the small bowel with sparing of the colon following distal aortic reconstructive surgery is exceedingly rare. Since 1961, it has been described in the literature on only a few occasions.[1–3] Although rare, this often fatal complication probably is preventable.[4, 5]

Connally[6] has emphasized the importance of the "meandering artery of the colon" on abdominal aortograms. When this vessel is seen, one should suspect that there is mesenteric artery occlusion and that the inferior mesenteric artery is contributing to the small bowel's blood supply. In order to recognize this circumstance, it is necessary to obtain a lateral abdominal aortogram or selective arteriography even though the standard anterior posterior view displays a normal mesenteric circulation. The disastrous consequences of ignoring the telltale warnings of the abdominal aortogram are insufficiently emphasized in the literature.

The following report describes a case of gangrene of the small bowel which was fatal on the third postoperative day following bilateral aorto-femoral bypass with inferior mesenteric artery ligation. It is being presented as an unusual complication of abdominal aortic surgery and points out the need for a thorough knowledge of the mesenteric circulation and its accurate evaluation in patients preoperatively. In patients requiring aorto-iliac reconstruction, visualization of the meandering or marginal artery of the colon on the aortogram should be a warning of coexisting sup
mesenteric artery occlusion.

The case described in this report is presented as an unusual complication of abdominal aortic surgery and points out the need for a thorough knowledge of the mesenteric circulation and its accurate evaluation in patients preoperatively. The authors are in the private practice of thoracic and vascular surgery.

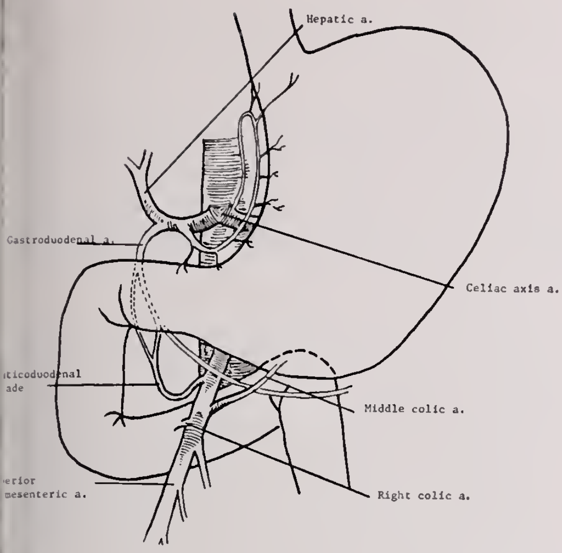
Case Report

A 61-year-old man was admitted to the Missouri
ta Community Hospital on Dec. 26, 1972 with
plaints of pain and discoloration of the right grea
which had progressed over one week. There w
three-year history of 50-yard intermittent claudic
involving both legs and being more pronounced i
left leg. The pain was described as being from
thighs to the knees.

On admission, blood pressure was 110/80; pulse
70; respiration rate, 18. Positive physical findings
a short asymptomatic right carotid bruit, markedl
duced femoral pulses with a soft bruit on the right
absence of pulses in the lower extremities bilate
and cyanosis of the hallux and second toe on the
foot with changes progressing approximately 2
cephalad from the tip of the toe. The clinical im
sion was that the patient had severe aorto-iliac o
sive disease and had recently sustained a thromb
episode of the small vessels of the right first and se
toes. A translumbar aortogram revealed severe art
sclerosis of the distal abdominal aorta, moderate
nosis of the right common iliac and complete lac
visualization of the left common and external iliac
teries. Both superficial femoral arteries were mode
ly involved. A large, wandering mesenteric artery
noted, and the trunk and branches of the superior
enteric artery were clearly visualized.

At operation, a bilateral aorto-femoral bypass
right lumbar sympathectomy were performed.
proximal anastomosis was done end-to-end. For
reason, the inferior mesenteric artery was ligated.
patient maintained a steady blood pressure and th
was no change in the color of the bowel. Postoperat
ly, the patient had good pulses in both legs, maintai
a stable blood pressure and did well for two days.
the third day, the patient became suddenly hypo
sive, deeply comatose, had a progressively dow
course and died that evening.

Autopsy revealed infarction of the small bowel f
the midportion to within 10 cm of the ileocecal v
and generalized arteriosclerosis. The first 3 cm of
superior mesenteric artery trunk was completely



g. 1 Blood supply to the foregut and the anastomosis een celiac and superior mesenteric arteries. The major nels are labeled.

ed by old plaque. The celiac artery was occluded *very* recent thrombus, which was not thought to ld enough to account for the small bowel infarc- The prosthesis was patent.

USSION

econstructive surgery of the distal aorta is being increasingly common. The earlier proximal to-side anastomosis, which does not require lin of the inferior mesenteric artery, is being aced by an end-to-end anastomosis between a and graft. This anastomosis often requires ion of the inferior mesenteric artery. The y of such ligation has repeatedly been shown e due to an abundant collateral system.[7] When collaterals are demonstrably compromised peratively, however, the safety of such liga- is questionable.

ne intra-abdominal gut is primarily supplied hree separate but interconnected arterial sys-, each with abundant collaterals. The foregut, stomach and duodenum, is nourished by the c artery and its branches. The midgut deriva- (jejunum, ileum, ascending and transverse n) are supplied by the superior mesenteric ar- while the hindgut derivatives (descending, oid colon and rectum) get their supply from inferior mesenteric. There are three important constant systems collateral to the superior and ior mesenteric arteries. They are the pancre-duodenal arcade, the left colic-middle colic ial anastomosis and the hypogastric artery sys- (Figs. 1 & 2). The pancreaticoduodenal arcade connects the celiac axis with the superior mesenteric artery while the inferior mesenteric artery is connected to the hypogastrics via the rich anastomosis between the superior rectal artery and the middle and inferior rectal arteries.

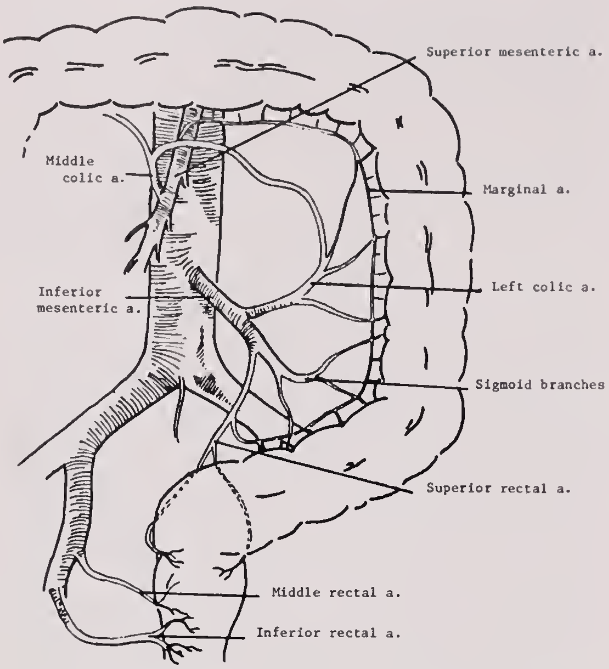


Fig. 2 Connections between the superior and inferior mesenteric arteries and the anastomotic network between the inferior mesenteric artery and the hypogastric branches to the rectum. The major channels are, again, labeled.

The left colic-middle colic anastomosis is the channel between the superior and inferior mesenteric arteries. With occlusion of either mesenteric artery, it is capable of supplying the bowel originally supplied by the occluded artery. Strandness[8] describes a case in which the entire blood supply to the upper abdomen was from the inferior mesenteric artery via this anastomosis. Under these circumstances, this anastomosis will greatly enlarge, become tortuous and will be well visualized on an aortogram. It is given the name "wandering mesenteric artery" (Figs. 1 & 2). This artery (anastomosis) is rarely seen radiographically in normal patients and by itself, it is sufficient evidence of a major mesenteric artery occlusion. It was emphasized by Moskowitz[9] that this artery represents an enlargement of the left colic-middle colic anastomosis and not the marginal artery of Drummond. He noted that with occlusion of the superior mesenteric artery at the trunk, flow through the "meandering artery of the colon" is from the inferior mesenteric artery cephalad.

Inferior mesenteric artery occlusion may give rise to a wide variety of clinical and pathological findings from infarction to total absence of symptoms, with symptoms of abdominal angina, hemorrhage, ulceration and stricture in between. The degree of pathology seen and its eventual recovery depends on the status of other mesenteric arteries and their collaterals, as well as the abruptness of the occlusion which may or may not permit the development of collateral circulation.

Ischemia of the left colon is a recognized complication following reconstructive surgery of the distal abdominal aorta.[10–12] It occurs in 1% to 2% of cases when the inferior mesenteric artery is interrupted as part of the procedure. Young[13] reviewed the literature and found 42 cases of large bowel ischemia with 23 deaths, emphasizing the importance of the collateral mesenteric circulation and ligation of the inferior mesenteric artery in the presence of an already compromised vascular arterial supply. Reiner[14] concluded that the bowel will remain viable in the face of inferior mesenteric artery occlusion, if collaterals are intact.

The entity we are describing is different from the "aorto-iliac steal." The aorta-iliac steal phenomenon is not contingent on physical interference with the existing mesenteric blood supply, but it is a "stealing" or "shifting" of mesenteric blood in the presence of preexisting mesenteric insufficiency. In his original article describing the aorto-iliac steal,[15] Koutz presented a patient with arteriosclerotic narrowing of the mesenteric vessels who developed gangrene of the small bowel after lumbar sympathectomy and ilio-femoral bypass. Lancaster[16] believed that the aorta-iliac steal syndrome was on a hemodynamic basis and that following vascular bypass, blood is stolen or redistributed from the mesenteric circulation to the periphery resulting in intestinal ischemia.

In our case, occlusion of the trunk of the superior mesenteric artery could have been diagnosed preoperatively from a lateral abdominal aortogram or selective arteriography. As seen here, the A-P view gives a false sense of security. Intestinal ischemia following vascular surgery must be prevented by preoperative planning.[4, 5]

Sacrifice of the inferior mesenteric artery at operation is not always necessary and should be avoided when not mandatory. It is technically possible to reimplant the vessels leaving a cuff of aorta around the orifice for suture.

As pointed out by Connally,[6] when the wandering artery of the colon appears on the aortogram, the surgeon, by palpation, must assure himse patency of the entire superior mesenteric artery fore violating the inferior mesenteric vessel. ply occluding the latter with a vascular clam a few minutes while inspecting the left colon not insure the surgeon against subsequent disa Hill[6] pointed out that abdominal angina may sue as much as nine years after ligation of th ferior mesenteric artery in a patient with imal, end-to-end, aorto-iliac graft.

We believe that the tragic outcome of our should be viewed in the light of three co-exis factors, as follows:

1. Sacrifice of the inferior mesenteric artery flow in this vessel was towards the superior enteric artery because of the truncal occlu of the latter.
2. Postoperative aorto-iliac steal.
3. Impaired flow in celiac-superior mesenteric tery collaterals due to recent thrombosis of celiac artery.

SUMMARY

A case of gangrene of the small bowel foll ing an aorto-femoral bypass procedure has been scribed. An explanation has been offered in light of both the role of the mesenteric circ tion and its collaterals, as well as the exacerba role of the aorto-iliac steal phenomenon. complication can be avoided by preopera awareness of signs and symptoms of mesenteric tery insufficiency and operative correction eithe reinsertion of the inferior mesenteric artery the aorta, revascularization of the superior me teric artery or by end-to-side proximal aorta graft anastomosis.

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valuation of Hyperparathyroidism hrough a Reference Laboratory

The use of multiple channel AutoAnalyzers has identified a significant group of patients with abnormalities of calcium and phosphate metabolism. This study evaluates the use of a reference laboratory to measure serum parathyroid hormone values by radioimmunoassay in the differential diagnosis of hypercalcemia. The authors are from St. Luke's Hospital where Dr. Burch is a Resident in Clinical Pathology and Dr. O'Kell is Chairman, Department of Pathology.

E 1891 when von Recklinghausen described fi- ystic disease of bone, many investigators have d to our knowledge of hyperparathyroidism. 904, Askanazy suggested, on the basis of post- em findings, the association of parathyroid tu- and fibrocystic disease of bone.[1] Secondary rparathyroidism in a patient with osteomalacia to vitamin D deficiency was described in 1906 rdheim.[1] The first successful treatment of hy- arathyroidism was recorded in 1926 when dl removed a parathyroid adenoma from a pa- with bone disease.[1]

urther insight into the problem came when ner and Tisdall devised a method of measur- calcium in small samples of blood.[2] With this Albright[1] began his classic study of hyper- thyroidism.

e advent of multiple channel analyses of d in routine screening programs has identified gnificant population with abnormalities of cal- and phosphate metabolism. After routine have been completed, even large hospitals may ire the assistance of a reference laboratory to in the diagnosis of hyperparathyroidism. This y describes the use of a radioimmunoassay for an parathyroid hormone (PTH) performed reference laboratory in the differential diag- of hypercalcemia.

ERIALS AND METHODS

tients in this study were from the medical and ical services of St. Luke's Hospital in Kansas . The mean age of the patients was 51 years. dmission, a routine SMA-12/60 was performed he sera of all patients.[3] When there was an ele- d calcium, another sample of the patient's sera analyzed on the same multiple channel ma- e. Serum alkaline phosphatase also was run on patient using the SMA-12/60. The tubular re- rption of phosphate (TRP) was done using SMA-12/60 as ordered by the attending physi- .

Radiographs of the hands and skull were not done on all patients. Bone scans and renal urograms were used when indicated by symptomatology. The radioimmunoassay of PTH was performed at the Department of Endocrine Research of the Mayo Clinic using the method of Arnaud, Littledike and Tsao.[4] This method uses an antiporcine PTH antibody which cross reacts with both human and bovine PTH. Bovine PTH labeled with Iodine^{131} is used as a radioactive primary reactant. Purified human PTH in varying concentrations is used as a standard. Generally, values less than 40 μl Eq/ml are considered normal.[4] After screening a large population of normal and abnormal sera, Arnaud and his group constructed a regression line relating the level of the patient's serum calcium to the level of PTH.[4] Regression lines were constructed for the 95th and the 99th percentiles. In our interpretation, patients having PTH values above the 99th percentile were considered to have elevated levels of PTH. Those between the 95th and 99th percentiles were considered borderline results.

RESULTS

Sixty-seven patients were selected on the basis of elevated or decreased calcium or on the basis of suggestive symptomatology. From this group, 41 pa-

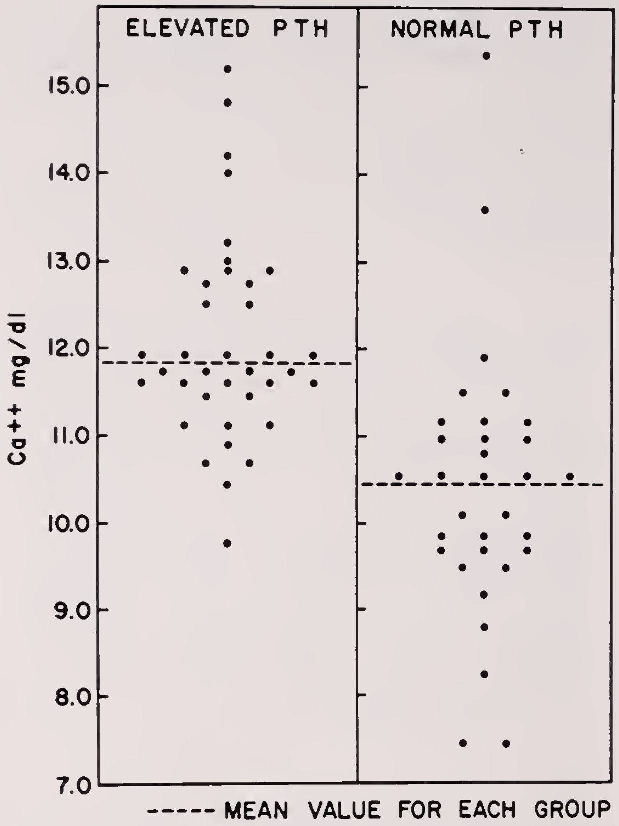

Fig. 1 Patients with elevated PTH had consistently higher serum calcium values. There is considerable overlap between the two groups.

tients (63%) had serum calcium higher than the upper limits of normal of 10.5 mg/dl.[5] There was a small group of three patients (5%) with serum calcium below 8.5 mg/dl who were being evaluated for hypoparathyroidism. Since the normal range of the radioimmunoassay for PTH extends to zero, this test is primarily helpful in ruling out the diagnosis of hyperparathyroidism. Serum phosphate was generally quite variable. There were 23 patients (35%) with serum phosphate below 2.5 mg/dl.[5] Generally, this was associated with high serum calcium. However, many patients with elevated calcium had normal or elevated phosphate.

Thirty-five patients (54%) had elevated PTH values. Although only four (12%) had definite chronic renal failure, 26% of patients with elevated PTH value had a history of recurrent stones or nephrocalcinosis. Four patients (12%) had a history of peptic ulcer disease. There were no patients with complaints of bone pain or x-ray evidence of serious bone disease due to hyperparathyroidism. The average serum calcium of the elevated PTH group was 11.9 mg/dl with a serum phosphate of 2.5 mg/dl. In contrast, in the group with normal PTH values, the average serum cium was 10.3 mg/dl and serum phosphate was mg/dl (Fig. 1). Of patients with elevated P five (14%) had evidence of renal disease w only 3% of the normal PTH group had renal pairment.

There was a subgroup of patients with hype cemia who had documented malignancies of ous kinds. These included two squamous cell cinomas of the lung, one adenocarcinoma of breast, one squamous cell carcinoma of the pe one radiographically diagnosed pituitary tu and one patient with multiple myeloma. Of group, two of the patients had borderline F values. Both patients with lung tumor and the tient with carcinoma of the breast had elev PTH values. The patient with squamous cell cinoma of the penis had a borderline PTH va In two larger series, primary hyperparathyroid could be separated from hyperparathyroidism sociated with nonparathyroid neoplasms.[6, 7] tients with "ectopic hyperparathyroidism" o have mildly elevated PTH with serum calcium proportionately high for the minimal PTH ele tion.[6, 7] This small series concurs with these fi ings.

Of the 35 patients with elevated PTH values, had neck exploration (Table 1). Two patie were explored without findings consistent w adenoma or hyperplasia. These patients had P values of 44 μl Eq/ml and 68 μl Eq/ml, respectiv The possibility that aberrantly placed parathyr tissue is still present cannot be ruled out. Three tients were found to have hyperplasia of three more glands which were removed. Two of th patients were on chronic hemodialysis and h PTH values of 2,600 μl Eq/ml and 270 μl Eq/ml, spectively. The third was apparently primary perplasia of the parathyroid with a PTH value 250 μl Eq/ml.

The majority of patients who underwent ne exploration were found to have typical adenom of varying size. The PTH values of patients w adenomas varied from 33 μl Eq/ml to 610 μl Eq/ with an average of 170 μl Eq/ml. Although it c generally be said that patients with hyperpla had higher levels of parathyroid hormone, ma of the large adenomas had values which were co parable. It, thus, was impossible to separate hyp plasia from adenoma prior to surgery.

Postoperatively, adenoma patients did well. M demonstrated a prompt drop in serum calciu ith a mild hypocalcemic phase (Fig. 2). Serum lcium on the average returned to normal by the nth postoperative day. No episodes of hypocal-mic tetany or pretetanic signs were observed.

The postoperative course of patients with hyper-asia was quite variable. One patient with renal ilure returned to a normocalcemic state. The her patients with hyperplasia after an initial op in serum calcium became mildly hypercalce-ic. Possibly, residual hyperplastic parathyroid tis-e continued to secrete enough PTH to maintain e hypercalcemic state.

One additional group should be mentioned. This nsisted of those patients who had PTH values tween the 95th and 99th percentiles (Table 2). n percent of patients in this series were in this

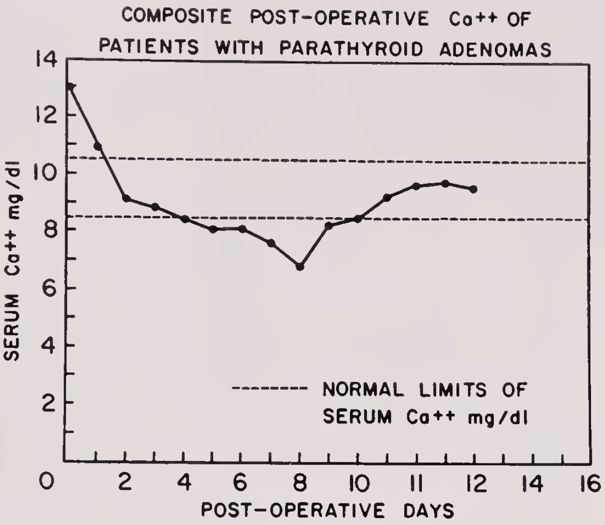

Fig. 2

TABLE 1

PATIENTS WITH ELEVATED PTH

Age	*Sex*	*Ca^{++} mg/dl*	*PO_4 mg/dl*	*Creatinine*	*PTH*	*Diagnosis*
72	F	11.8	1.3	0.7	57	*A, 273 mg
64	F	13.0	1.5	0.5	110	A, 1.03 gm
49	M	12.5	1.7	1.1	610	A, 2x3 cm
58	F	10.5	5.0	0.7	64	A, 1x1 cm
41	F	11.5	2.2	0.6	68	A
69	M	12.0	2.5	0.8	56	A, 1.8x1 cm
46	F	12.0	2.3	0.7	280	A, 4.5 gm
17	M	14.0	2.0	1.2	100	A, 1.3x1 cm
67	M	14.7	1.8	1.0	58	A, 2x1 cm
78	M	11.9	1.7	11.9	270	†H
52	F	12.2	2.6	1.0	250	H
58	F	10.8	2.6	9.5	2600	H
51	F	13.0	1.7	1.2	58	Neg exploration
62	M	12.0	2.3	0.7	56	Neg exploration
52	M	9.5	3.1	0.7	45	Carcinoma-penis
86	F	11.7	2.2	0.6	33	Carcinoma-breast
74	M	13.6	1.7	1.1	36	Sq Carcinoma-lung
68	M	15.2	2.6	1.8	46	Sq Carcinoma-lung
75	F	11.6	2.5	0.7	38	Osteoporosis
48	F	11.6	2.3	0.6	40	Diabetes mellitus
67	M	10.3	2.3	1.0	43	Renal calculus
52	F	11.3	2.8	1.1	56	Neg
52	F	11.5	2.7	1.2	33	Peptic ulcer
42	M	11.5	3.3	0.8	38	Renal calculus
58	M	11.0	2.6	1.5	60	Peptic ulcer
75	F	9.9	3.3	6.8	84	Renal failure
43	M	10.5	3.8	0.7	46	Renal calculus
49	F	12.5	1.8	0.6	85	Renal calculus
44	F	10.5	4.5	0.6	70	Neg
52	F	11.6	2.2	1.0	42	Neg
69	F	11.2	2.8	0.7	58	Neg
74	M	11.5	1.7	0.7	62	Hyperthyroidism
79	F	11.0	2.7	0.9	79	Neg
83	F	12.8	2.5	1.6	660	Neg
68	M	15.0	2.6	1.8	1000	Renal failure

A: Parathyroid adenoma.
H: Parathyroid hyperplasia.

TABLE 2

PATIENTS WITH NORMAL PTH

Age	*Sex*	*Ca++ mg/dl*	*PO_4 mg/dl*	*Creatinine*	*PTH*	*Diagnosis*
48	M	11.0	4.0	1.0	27	Pituitary tumor, diabetes insip.
81	M	12.5	4.1	2.8	16	Multiple myeloma
54	F	10.5	3.2	1.0	30	Hyperthyroidism
55	M	10.6	2.5	1.0	39	Renal calculus
60	F	10.8	3.2	0.7	25	Neg Hx
21	M	9.8	4.1	1.4	30	Frequent Fx
50	F	11.0	1.5	0.8	34	Neg Hx
58	F	9.7	3.2	1.2	27	Rheum arth
50	M	10.2	2.8	1.1	32	Neg Hx
59	M	7.2	4.3	1.0	16	Thyroidectomy
42	F	10.5	3.7	0.8	21	Neg Hx
60	M	8.1	1.6	0.6	17	Neg Hx
32	F	8.8	4.0	1.0	22	Renal calculus
34	M	10.0	3.8	1.0	9	Acute pancreatitis
46	M	11.7	2.3	1.5	19	CAD
76	F	10.3	2.7	1.0	16	Renal calculus, peptic ulcer
44	F	9.0	3.6	2.0	32	Thyroidectomy, SLE, renal stones
20	M	10.8	3.8	0.8	19	Neg Hx
65	F	9.8	3.5	1.0	37	PAT with RHD
45	F	6.2	5.2	0.7	* U.D.	Thyroidectomy
18	F	11.2	2.2	1.0	26	Neg Hx
34	F	11.2	3.1	0.8	35	Anxiety neurosis
13	M	11.0	3.3	1.0	22	Renal calculus
32	M	9.5	2.0	1.0	22	Renal calculus
23	F	10.5	3.5	1.0	30	Multiple sclerosis
48	F	10.5	2.5	0.6	25	Hypertension
24	F	10.8	5.5	0.6	27	Toxemia-pregnancy
10	M	10.5	5.5	0.6	28	Gastric ulcer
40	M	9.5	3.0	1.0	* U.D.	Renal calculi
19	M	10.0	3.7	0.8	* U.D.	Renal stones, peptic ulcers
81	M	10.5	2.5	0.6	25	Neg Hx
43	F	10.3	3.4	1.0	26	SLE

* U.D.: undetectable.

category. Serum calcium in this group averaged 10.7 mg/dl with normal serum phosphate. Tubular resorption of phosphate was normal. On serial determinations, four patients (55%) had normal calcium values. The possibility that this group might represent early parathyroid disorders cannot be answered without further follow-up.

Discussion

Recognition of patients with hyperparathyroidism may be difficult. Symptoms such as muscular weakness, anorexia, nausea and constipation may easily be attributed to more common disorders.[8, 9] Polyuria and polydipsia due to excessive loss of calcium, phosphate, sodium, potassium, and renal tubular dysfunction may also at first prompt studies for other diseases.[9] Renal stones (especiall recurrent), pancreatitis, peptic ulcer, bone pai and spontaneous bone fracture have long bee known to be associated with hyperparathyroidism.[10] In these instances, further study of parathyroid function are certainly warranted.

Presently due to the accessibility of modern laboratories, even small hospitals can utilize low-cost multiple channel screening methods. When interpreting such tests, simultaneous serum albumi should be evaluated with the serum calcium levels This is important because marked hypoalbuminemia (with accompanying decrease in calcium proteinate) may mask an increase in diffusable ionized calcium.[11]

Such tests as tubular resorption of phosphate

d cortisone suppression tests may be helpful as
pportive evidence.[12] Radioimmunoassay for hu-
n PTH has proved helpful in separating pa-
nts with hyperfunctioning parathyroid tissue
m patients with secondary causes of hypercal-
mia.[7] With the use of routine screening methods
d judicious use of more sophisticated tests, such
radioimmunoassay for human PTH, it should
possible to recognize patients with early hyper-
rathyroidism. In this way, elective surgery, in
e majority of cases, can eliminate the cause, stop
e damaging effects of excessive PTH excretion
both bones and kidney and prevent the rare but
e-threatening occurrence of acute hypercalcemic
ndrome.

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LESTER E. WALL, M.D., ***St. Lou***

Cromolyn Sodium in Pediatric Asthma Therapy

Cromolyn sodium is an adjunctive drug for the treatment of perennial asthma having a consistent, reasonably predictable pattern of severity. It is a bischrome compound and is manufactured as a white, hygroscopic, crystalline powder. The drug is known to be poorly absorbed when taken orally, but when inhaled by using a special turbo inhaler device, an estimated 8% or 9% of the administered dose reaches the bronchial tree—its site of action—and is absorbed systemically.[1] The rest of the powder is primarily swallowed or exhaled with a light dusting adhering to the inhaler. Half of the absorbed dose is excreted unchanged in the bile and half appears in the urine.

While the exact mode of action of cromolyn sodium remains to be clarified, the drug apparently inhibits the allergic reaction to antigen challenge by preventing or inhibiting the release of mediators from the mast cells of bronchial smooth muscle.[2] However, recent evidence suggests that the drug can act as an inhibitor of cAMP phosphodiesterase.[3] Cromolyn sodium has no bronchodilator, anti-inflammatory or antihistaminic activity. Therefore, it must be given prophylactically, i.e., before the onset of the attack as it seems to have no effect once the attack has started.

The reported incidence of side effects is low, and over 250 clinical studies with cromolyn sodiu have been conducted throughout the world. In p diatric asthma, particularly, it has been shown be effective in reducing the severity of sympton (wheezing, night cough, tightness, etc.) and in r ducing the dependence upon bronchodilators a corticosteroids, ultimately reducing the rate of ho pitalization.[4–6] The present study was undertake to further define the drug's efficacy and safet Also, previous studies with cromolyn sodium hav suggested the presence of a "carry-over" effect drug action after the treatment has been halted Therefore, this was an additional factor that wa examined.

A placebo-controlled, double-blind, 12-week cross-over study was conducted with cromolyn sodium in 34 asthmatic pediatric patients to determine the drug's efficacy, safety and reported "carry-over" effect. An analysis group of 29 patients had a significant reduction in symptom severity while using the active drug. Of the total 34 patients, the majority had a subjective preference for cromolyn sodium treatment over placebo. The "carry-over" effect was not seen in this trial. Dr. Wall is Assistant Clinical Professor of Pediatrics, St. Louis University School of Medicine.

Materials and Methods

Thirty-four patients seen in private practic were entered in a randomized, double-blind, place bo-controlled, crossover study lasting 12 weeks. Be fore introduction into the trial, each patient an parent, together with the investigator, recorded prestudy evaluation of the patient's asthma b rating symptoms, such as wheeze, breathlessness tightness and cough. Entering the trial, each pa tient had a two-week baseline period in which h used only his regular medications, either inhaled orally or both. Next came the first four-week dru period during which the patient received 20 mg o cromolyn sodium (Aarane®) or placebo (35 mg of lactose plus 5 mg of sodium sulfate) by inhalation, using the special inhaler device four times day. This drug period was followed by two weeks of no experimental therapy. The 12-week tria ended with another four-week drug period in which the patient was "crossed-over" to either the active drug or placebo, depending upon which was given first (Table 1).

Patients were seen and evaluated at two-week intervals. At each visit, detailed records were made for statistical analysis and the two-weeks' asthma severity was rated on a zero-to-six scale by the physician. In addition, each patient kept day-and-night mptom severity scores during the entire 12-week al (Table 2). Laboratory tests were taken at the ginning, midpoint and conclusion of the study. iese included chest X-ray, blood creatinine, glu- se, BUN, uric acid, total bilirubin, total protein, oumin, gammaglobulin, A/G ratio, LDH, alka- e phosphatase, SGOT, cholesterol, as well as mplete blood count with MCV and hematocrit.

At the end of the 12-week trial, the patients' eferences for either compound, together with e reasons for this drug choice, were recorded be- re the drug code was broken.

SULTS

The majority of patients in this study were mod- ate to severe asthmatics with daily, predictable nifestations of asthma. Of an original group 34 patients, two exhibited an irregular use of rticosteroids and were excluded from statistical alysis because of the difficulties involved in operly accounting for the known but variable rry-over effects of corticosteroid use. Three other tients dropped out of the trial or yielded data at could not be evaluated for reasons unrelated the test drug. This left an *analysis group* of 29 tients, none of whom was using corticosteroids ring the trial.

The sequence 1 group of patients (active → pla- bo) was composed of eight males and seven fe- les; the sequence 2 group (placebo → active) had n males and four females. Thirteen patients re below ten years of age; 14 were aged ten to years; and two were over 17 years of age.

When data were analyzed for the whole group, table reductions were seen in the major four- ek symptom severity scores when the patient was eiving cromolyn sodium. The most significant ferences were seen in wheeze, p = .0016; tightness, = .0017; cough, p = .0027; and breathlessness, p =

TABLE 1

SCHEME OF TRIAL

Week	*Sequence* GROUP 1	 GROUP 2
1 - 2	Baseline	
3 - 4	Active	Placebo
5 - 6	Active	Placebo
7 - 8	No Therapy	
9 - 10	Placebo	Active
11 - 12	Placebo	Active

TABLE 2

DAY AND NIGHT RATINGS FOR SYMPTOMS OF WHEEZE, BREATHLESSNESS, TIGHTNESS, AND COUGH

Day	*Night*
0 = None	0 = None
1 = Trivial	1 = Asleep, others hear questionable symptom
2 = Mild, causing little or no discomfort	2 = Asleep, others hear definite symptom
3 = Annoying but not causing marked discomfort	3 = Awakened by symptom, no medication needed, returned to sleep
4 = Moderate, marked discomfort but not interfering with routine activities	4 = Awakened, medication taken, prompt return to sleep
5 = Severe, some interference with activity but not incapacitating	5 = Awakened, medication makes comfortable, but symptoms persist, remain awake
6 = Very severe, intolerable and incapacitating	6 = Intolerable, constant symptoms, unable to sleep because of asthma

TABLE 3

AVERAGE FOUR-WEEK SYMPTOM SCORES OF ANALYSIS GROUP PATIENTS

mptom	*Overall Mean: Cromolyn Sodium*	*Overall Mean: Placebo*	*Estimated Difference*	*p Value**
eeze	0.36	0.65	−0.29	.0016
athlessness at rest	0.15	0.42	−0.27	.0146
htness	0.16	0.41	−0.25	.0017
ıgh	0.30	0.60	−0.30	.0027
tum	0.19	0.23	−0.04	.5348
mber of attacks	2.10	6.00	−3.9†	.0715

Derived by Wilcoxon paired-comparison test.
Estimated in units of total number of attacks over the four-week drug period.

TABLE 4

SUMMARY OF STATISTICAL ANALYSIS OF THE TWO-WEEK EVALUATION SCORES—SIGNIFICANCE LEVE AND ESTIMATED DIFFERENCE BETWEEN CROMOLYN SODIUM AND PLACEBO SCORES OF THE *ANALYSIS GROUP* PATIENTS

Patient Subset	*Number*	*Overall Mean: Cromolyn Sodium*	*Overall Mean: Placebo*	*Estimated Difference**	*p value*†
All patients	29	0.98	1.74	–0.76	.0030
All patients not increasing their nebulizer and oral medication use while on cromolyn sodium	24	0.84	1.80	–0.96	.0005
Patients indicating a strong post-study preference for cromolyn sodium	14	0.72	2.22	–1.50	<.00005

* A negative difference indicates a lower average for cromolyn sodium scores.
† Derived by the Wilcoxon paired-comparison test.

.015 (Table 3). In addition, when each patient was asked to make an overall evaluation of his asthma after each two-week period (using a zero to six scale), the average reduction in overall symptom severity for the group also was highly significant, with p = .003 (Table 4).

The plot for the two-week average in number of attacks is shown in Fig. 1, illustrating the "crossover" effect. The two-week evaluation scores for sequence groups 1 and 2 showed a 0.75 rating reduction (see Table 2 for ratings) in symptom severity while the patient was using the active drug (Fig. 2).

When the total group of 34 patients were questioned for their preferences, 20 (59%) favored cromolyn sodium, while 12 (35.2%) of these p tients had some preference for placebo (Fig. A summary of the reasons given for these pr erences by the 14 *analysis group* patients w strongly preferred cromolyn sodium is shown Table 5; 93% stated their overall asthma was le severe.

Patients used less oral medication during t cromolyn sodium treatment period, but not enou to make a statistically significant difference (Tab 4). Only four patients used nebulized medicati during this trial, so a statistical analysis of the e fect of cromolyn sodium on this parameter w not justified.

No significant side effects to cromolyn sodiu

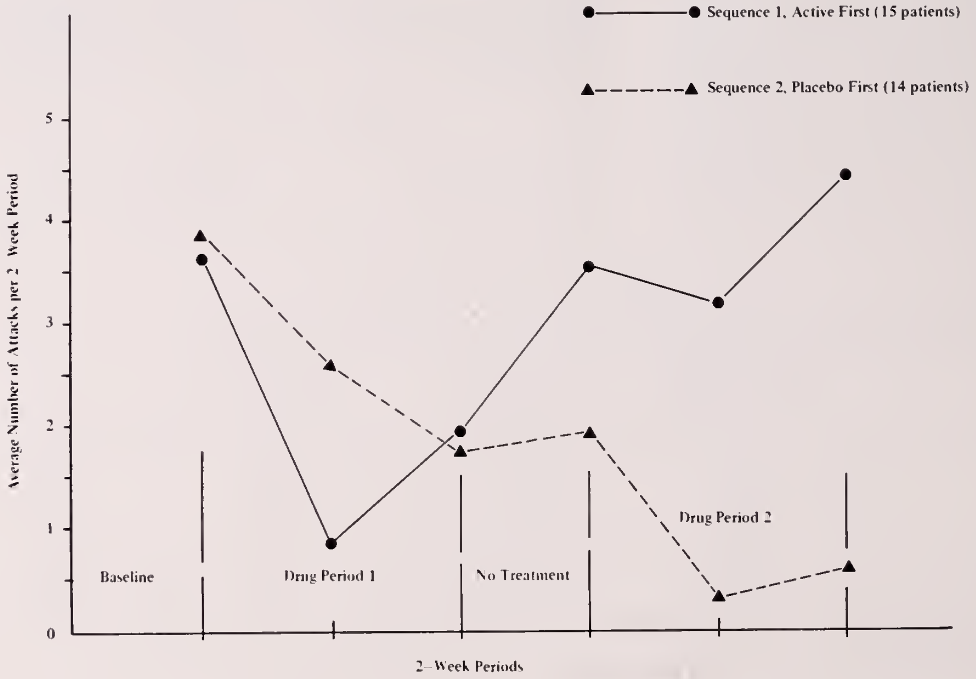

Fig. 1 Average numb of attacks per two-wee period (analysis group).

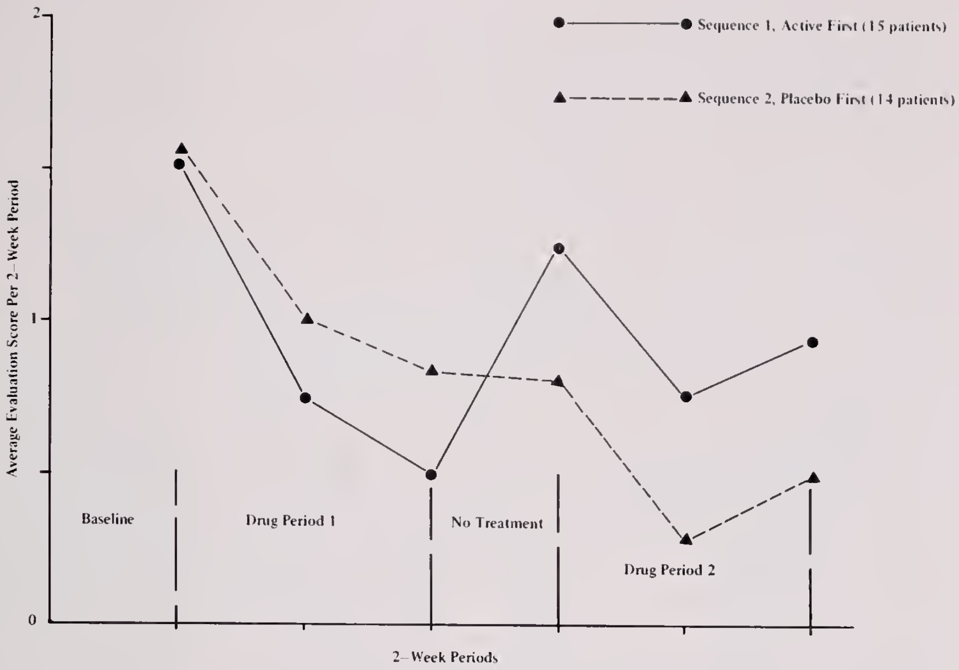

Fig. 2 Two-week evalua-
n scores (analysis group).

re noted. Complaints of "rawness of the chest" d "throat irritability," previously noticed by oth- researchers,[1, 5, 7] were not seen. Other recorded le effects, such as headache, nervousness and eplessness, represent symptoms well known to ac- mpany use of bronchodilators, such as isoproter- ol, ephedrine and theophylline. Most of these mplaints were found during the placebo phase the trial when, in fact, the patients were using onchodilators more frequently.

Results of laboratory tests were evaluated at the d of the trial, and all patients were found to ve values within normal limits.

One objective of this study was to determine ether cromolyn sodium has a "carry-over" effect suggested by other researchers.[7] Therefore, the gree of disease activity of the patients during e two-week "washout" period following the ac- e phase of the trial was carefully monitored and mpared with the baseline disease activity. The tients who received cromolyn sodium during the st drug phase of the study did not exhibit a sig- icant reduction in disease severity during the ashout" phase as compared with the patients o received placebo first. Therefore, a drug "car- -over" effect was not found in this study.

SCUSSION

The many reports in the literature on the effec- eness and acceptability of cromolyn sodium in ediatric population[1, 5, 6] are substantiated by the results of this trial: (1) sustained reduction in asthma symptom severity, (2) patient preference for the active drug, (3) paucity of side effects and (4) laboratory data within normal limits.

Symptom scores for both groups of patients did not reveal a significant reduction in disease severity during the two-week "washout" period. Therefore, a "carry-over" effect, such as reported by oth-

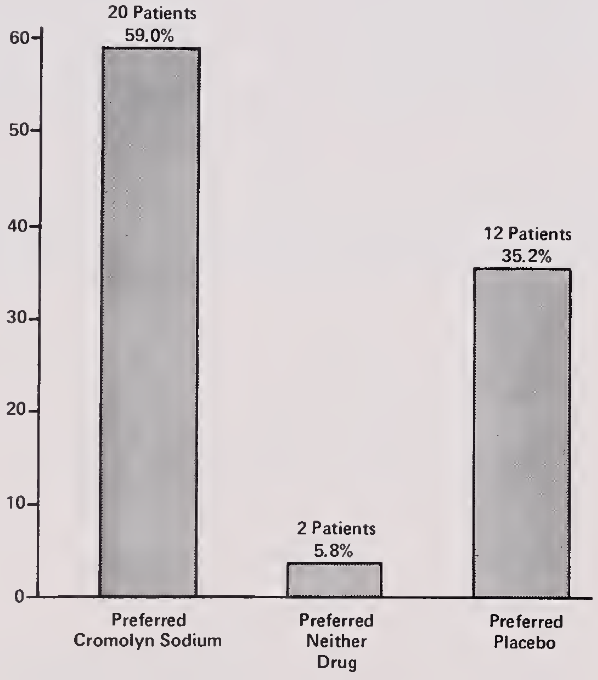

Fig. 3 Patient post-study drug preference.

TABLE 5

SUMMARY OF THE REASONS GIVEN BY 14 *ANALYSIS GROUP* PATIENTS STRONGLY PREFERRING CROMOLYN SODIUM*

Reason	*Number of Patients*	*Percent*
Overall asthma less severe	13	93
Isolated attacks less severe	12	86
Isolated attacks less frequent	13	93
Isolated attacks easier to manage	11	79
Ability to rest nights improved	12	86
Ability to play/exercise improved	11	79
Other reasons	7	50

* Four *analysis group* patients strongly preferred placebo.

er investigators,[7] was not seen in this study.

Patient acceptance of the active medication was good. The technique of administration via the inhaler device was easily learned by even the youngest children in this study.

A noticeable positive placebo effect was observed in the data. While cromolyn was clearly shown to have the greatest effect (Fig. 2), a placebo response is not unusual in a study of this nature with a hyperreactive disease, such as asthma. However, the placebo response, which has been noticed in other studies,[8] seems to be fairly transient.[9]

In conclusion, while further studies are required to ascertain the long-term effects of inhaling a powder on a regular basis, there is strong evidence to indicate that cromolyn sodium is a useful drug for treating asthmatic pediatric patients when used in conjunction with other modes of therapy.

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IMPORTANT INFORMATION: *This is a Schedule V substance by Federal law; diphenoxylate HCl is chemically related to meperidine. In case of overdosage or individual hypersensitivity, reactions similar to those after meperidine or morphine overdosage may occur; treatment is similar to that for meperidine or morphine intoxication (prolonged and careful monitoring). Respiratory depression may recur in spite of an initial response to Nalline® (nalorphine HCl) or Narcan® (naloxone HCl) or may be evidenced as late as 30 hours after ingestion. LOMOTIL IS NOT AN INNOCUOUS DRUG AND DOSAGE RECOMMENDATIONS SHOULD BE STRICTLY ADHERED TO, ESPECIALLY IN CHILDREN. THIS MEDICATION SHOULD BE KEPT OUT OF REACH OF CHILDREN.*

Indications: Lomotil is effective as adjunctive therapy in the management of diarrhea.

Contraindications: In children less than 2 years, due to the decreased safety margin in younger age groups, and in patients who are jaundiced or hypersensitive to diphenoxylate HCl or atropine.

Warnings: Use with special caution in young children, because of variable response, and with extreme caution in patients with cirrhosis and other advanced hepatic disease or abnormal liver function tests, because of possible hepatic coma. Diphenoxylate HCl may potentiate the action of barbiturates, tranquilizers and alcohol. In theory, the concurrent use with monoamine oxidase inhibitors could precipitate hypertensive crisis. In severe dehydration or electrolyte imbalance, withhold Lomotil until corrective therapy has been initiated.

Usage in pregnancy: Weigh the potential benefits against possible risks before using during pregnancy, lactation or in women of childbearing age. Diphenoxylate HCl and atropine are secreted in the breast milk of nursing mothers.

Precautions: Addiction (dependency) to diphenoxylate HCl is theoretically possible at high dosage. Do not exceed recommended dosages. Administer with caution to patients receiving addicting drugs or known to be addiction prone or having a history of drug abuse. The subtherapeutic amount of atropine is added to discourage deliberate overdosage; strictly observe contraindications, warnings and precautions for atropine; use with caution in children since signs of atropinism may occur even with the recommended dosage. Use with care in patients with acute ulcerative colitis and discontinue use if abdominal distention or other symptoms develop.

Adverse reactions: Atropine effects include dryness of skin and mucous membranes, flushing, hyperthermia, tachycardia and urinary retention. Other side effects with Lomotil include nausea, sedation, vomiting, swelling of the gums, abdominal discomfort, respiratory depression, numbness of the extremities, headache, dizziness, depression, malaise, drowsiness, coma, lethargy, anorexia, restlessness, euphoria, pruritus, angioneurotic edema, giant urticaria, paralytic ileus, and toxic megacolon.

Dosage and administration: ***Lomotil is contraindicated in children less than 2 years old.*** Use only Lomotil liquid for children 2 to 12 years old. For ages 2 to 5 years, 4 ml. (2 mg.) t.i.d.; 5 to 8 years, 4 ml. (2 mg.) q.i.d.; 8 to 12 years, 4 ml. (2 mg.) 5 times daily; adults, two tablets (5 mg.) t.i.d. to two tablets (5 mg.) q.i.d. or two regular teaspoonfuls (10 ml., 5 mg.) q.i.d. Maintenance dosage may be as low as one fourth of the initial dosage. Make downward dosage adjustment as soon as initial symptoms are controlled.

Overdosage: Keep the medication out of the reach of children since accidental overdosage may cause severe, even fatal, respiratory depression. Signs of overdosage include flushing, hyperthermia, tachycardia, lethargy or coma, hypotonic reflexes, nystagmus, pinpoint pupils and respiratory depression which may occur 12 to 30 hours after overdose. Evacuate stomach by lavage, establish a patent airway and, when necessary, assist respiration mechanically. A narcotic antagonist may be used in severe respiratory depression. Observation should extend over at least 48 hours.

Dosage forms: Tablets, 2.5 mg. of diphenoxylate HCl with 0.025 mg. of atropine sulfate. Liquid, 2.5 mg. of diphenoxylate HCl and 0.025 mg. of atropine sulfate per 5 ml. A plastic dropper calibrated in increments of ½ ml. (total capacity, 2 ml.) accompanies each 2-oz. bottle of Lomotil liquid.

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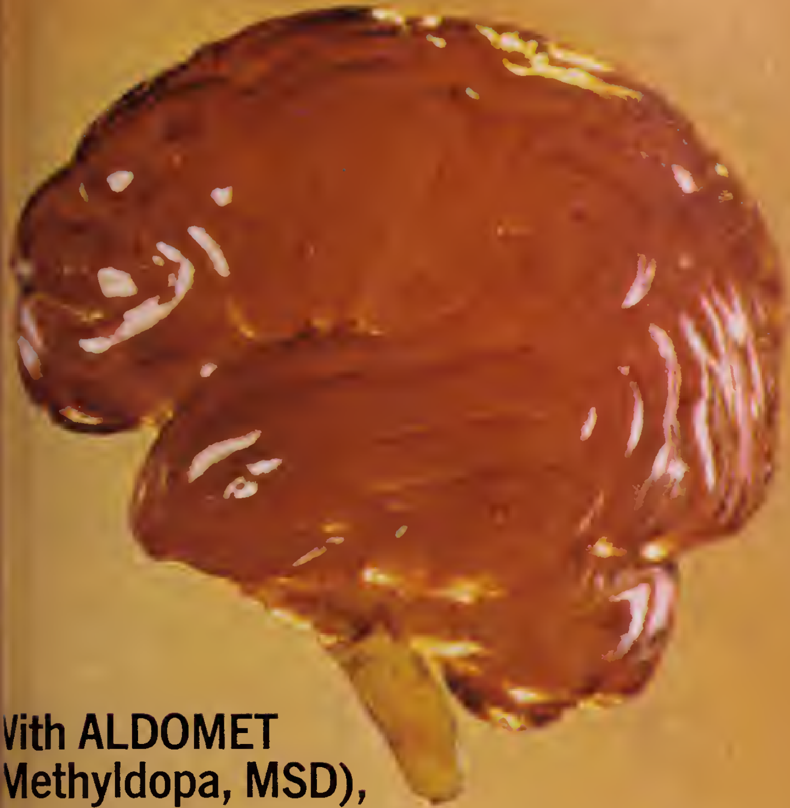

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ith ALDOMET than with many other antihypertensive agents.
xercise hypotension and diurnal blood pressure variations
rely occur.

or hypertension

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METHYLDOPA|MSD)

unique antihypertensive agent

DOMET is contraindicated in active hepatic disease,
ypersensitivity to the drug, and if previous methyldopa
erapy has been associated with liver disorders. It is
ot recommended in pheochromocytoma.
is important to recognize that a positive Coombs test,
emolytic anemia, and liver disorders may occur with
ethyldopa therapy. The rare occurrences of hemolytic anemia
liver disorders could lead to potentially fatal complica-
ons unless properly recognized and managed. For more
etails see the brief summary of prescribing information.

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or a brief summary of prescribing information, please see following page.

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- **easier for patients to remember**

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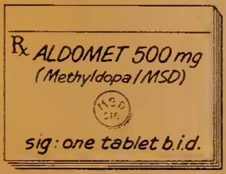
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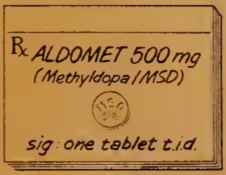
(Methyldopa/MSD)
sig: one tablet b.i.d.

1.5-g daily dose =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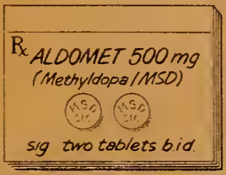
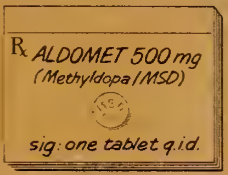
2.0-g daily dose =


℞ *ALDOMET 500 mg*
(Methyldopa/MSD)
sig: two tablets b.i.d.


℞ *ALDOMET 500 mg*
(Methyldopa/MSD)
sig: one tablet q.i.d.

NOTE: Tablets shown are not actual size.

in hypertension

ALDOMET®(METHYLDOPA|MSD)

usually lowers blood pressure effectively

Contraindications: Active hepatic disease, such as acute hepatitis and active cirrhosis; if previous methyldopa therapy has been associated with liver disorders (see Warnings); hypersensitivity

Warnings: It is important to recognize that a positive Coombs test, hemolytic anemia, and liver disorders may occur with methyldopa therapy. The rare occurrences of hemolytic anemia or liver disorders could lead to potentially fatal complications unless properly recognized and managed. Read this section carefully to understand these reactions.

With prolonged methyldopa therapy, 10% to 20% of patients develop a positive direct Coombs test, usually between 6 and 12 months of therapy Lowest incidence is at daily dosage of 1 g or less. This on rare occasions may be associated with hemolytic anemia, which could lead to potentially fatal complications. One cannot predict which patients with a positive direct Coombs test may develop hemolytic anemia. Prior existence or development of a positive direct Coombs test is not in itself a contraindication to use of methyldopa. If a positive Coombs test develops during methyldopa therapy, determine whether hemolytic anemia exists and whether the positive Coombs test may be a problem. For example, in addition to a positive direct Coombs test there is less often a positive indirect Coombs test which may interfere with cross matching of blood

At the start of methyldopa therapy, it is desirable to do a blood count (hematocrit, hemoglobin, or red cell count) for a baseline or to establish whether there is anemia. Periodic blood counts should be done during therapy to detect hemolytic anemia It may be useful to do a direct Coombs test before therapy and at 6 and 12 months after the start of therapy. If Coombs-positive hemolytic anemia occurs, the cause may be methyldopa and the drug should be discontinued. Usually the anemia remits promptly If not, corticosteroids may be given and other causes of anemia should be considered. If the hemolytic anemia is related to methyldopa, the drug should not be reinstituted. When methyldopa causes Coombs positivity alone or with hemolytic anemia, the red cell is usually coated with gamma globulin of the IgG (gamma G) class only The positive Coombs test may not revert to normal until weeks to months after methyldopa is stopped.

Should the need for transfusion arise in a patient receiving methyldopa, both a direct and an indirect Coombs test should be performed on his blood. In the absence of hemolytic anemia, usually only the direct Coombs test will be positive. A positive direct Coombs test alone will not interfere with typing or cross matching. If the indirect Coombs test is also positive, problems may arise in the major cross match and the assistance of a hematologist or transfusion expert will be needed.

Fever has occurred within first 3 weeks of therapy, sometimes with eosinophilia or abnormalities in liver function tests, such as serum alkaline phosphatase, serum transaminases (SGOT, SGPT), bilirubin, cephalin cholesterol flocculation, prothrombin time, and bromsulphalein retention. Jaundice, with or without fever, may occur, with onset usually in the first 2 to 3 months of therapy. In some patients the findings are consistent with those of cholestasis. Rarely fatal hepatic necrosis has been reported. These hepatic changes may represent hypersensitivity reactions; periodic determination of hepatic function should be done particularly during the first 6 to 12 weeks of therapy or whenever an unexplained fever occurs. If fever and abnormalities in liver function tests or jaundice appear, stop therapy with methyldopa. If caused by methyldopa, the temperature and abnormalities in liver function characteristically have reverted to normal when the drug was discontinued. Methyldopa should not be reinstituted in such patients.

Rarely, a reversible reduction of the white blood cell count with primary effect on granulocytes has been seen. Reversible thrombocytopenia has occurred rarely. When used with other antihypertensive drugs, potentiation of antihypertensive effect may occur. Patients should be followed carefully to detect side reactions or unusual manifestations of drug idiosyncrasy.

Use in Pregnancy: Use of any drug in women who are or may become pregnant requires that anticipated benefits be weighed against possible risks; possibility of fetal injury can not be excluded.

Precautions: Should be used with caution in patients with history of previous liver disease or dysfunction (see Warnings) May interfere with measurement of: uric acid by the phosphotungstate method, creatinine by the alkaline picrate method, and SGOT by colorimetric methods. Since methyldopa causes fluorescence in urine samples at the same wavelengths as catecholamines, falsely high levels of urinary catecholamines may be reported This will interfere with the diagnosis of pheochromocytoma It is important to recognize this phenomenon before a patient with a possible pheochromocytoma is subjected to surgery. Methyldopa is not recommended for patients with pheochromocytoma. Urine exposed to air after voiding may darken because of breakdown of methyldopa or its metabolites.
Stop drug if involuntary choreoathetotic mov
occur in patients with severe bilateral cerebr
lar disease. Patients may require reduced d
anesthetics; hypotension occurring during
thesia usually can be controlled with vasopr
Hypertension has recurred after dialysis in
on methyldopa because the drug is removed
procedure.

Adverse Reactions: *Central nervous*
Sedation, headache, asthenia or weakness,
early and transient; dizziness, lighthead
symptoms of cerebrovascular insuffi
paresthesias, parkinsonism, Bell's palsy, de
mental acuity, involuntary choreoathetotic
ments; psychic disturbances, including nigh
and reversible mild psychoses or depression
Cardiovascular: Bradycardia, aggravation of
pectoris. Orthostatic hypotension (decreas
dosage). Edema (and weight gain) usually
by use of a diuretic. (Discontinue methyl
edema progresses or signs of heart failure a
Gastrointestinal: Nausea, vomiting, distentio
stipation, flatus, diarrhea, mild dryness of mou
or "black" tongue, pancreatitis, sialadenitis.
Hepatic: Abnormal liver function tests, ja
liver disorders.
Hematologic: Positive Coombs test, he
anemia. Leukopenia, granulocytopenia,
bocytopenia.
Allergic: Drug-related fever, myocarditis.
Other: Nasal stuffiness, rise in BUN, breast
ment, gynecomastia, lactation, impotence, de
libido, dermatologic reactions including eczen
lichenoid eruptions, mild arthralgia, myalgia.

Note: Initial adult dosage should be lim
500 mg daily when given with antihyperte
other than thiazides. Tolerance may occur,
between second and third month of thera
creased dosage or adding a thiazide fre
restores effective control. Patients with im
renal function may respond to smaller dose
cope in older patients may be related to inc
sensitivity and advanced arteriosclerotic v
disease; this may be avoided by lower dose

How Supplied: Tablets, containing 1
methyldopa each, in bottles of 100; Tablets, c
ing 250 mg methyldopa each, in singl
packages of 100 and bottles of 100 and
Tablets, containing 500 mg methyldopa ea
single-unit packages of 100 and bottles of 1
For more detailed information, consult you
representative or see full prescribing inf
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SP-76-A

President's Message

Of the various programs currently being conducted by the Missouri State Medical Association, the continuing medical education program (CME), as approved by the 1971 House of Delegates, is probably one of the most important.

On Jan. 1, 1976, the MSMA will implement this voluntary continuing medical education program under the auspices of the American Medical Association in order to serve as an accrediting body for institutions and organizations which provide local CME activities in the state of Missouri.

I would like to urge each physician to take advantage of the opportunities that this program will provide. The concept of "lifetime learning" has become an accepted fact among practicing physicians. It is a necessity in order to maintain a level of competence that will assure quality patient care.

Missouri physicians are fortunate to have a *voluntary* continuing medical education program, since several states have laws making it mandatory for physicians to have a certain number of hours for recertification and relicensure. Along with these legislative acts, there are other regulations currently being proposed that will make it a necessity for physicians to have documented evidence of continuing medical education in order to maintain medical staff membership and privileges.

I am sure we will agree that in order for this program to be successful, each physician's participation is greatly needed. Strong participation in Missouri's continuing medical education program will help assure that this program will remain on a voluntary basis.

R. Allen Chandler, M.D.

Within the next few weeks, you will receive by mail a folder which has been designed for your convenience in recording your continuing medical education activities. Periodically, this manila folder will be mailed back to the MSMA Headquarters so that your CME activities can be recorded. You will find more information on this mailing in the *News Roundup* section of this issue.

Through this well designed and implemented program, MSMA members have an excellent opportunity to continue their education with a minimum of travel and expense. I heartily endorse this fine program and encourage your participation.

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Woman's Auxiliary

Every Physician's Wife Speaks for the Profession

Every physician's wife DOES speak for the profession. Whether it is good or bad, she is looked upon by the public as representing the field of medicine. She must be trained to do it knowledgeably. Hence, our MSMA Auxiliary's Fall Conference sessions in Sedalia in October were directed toward training in leadership for county auxiliary units. Topics covered included money matters, the art of communication, leadership skills, using the resources of our organization, fund raising techniques, a legislative workshop and information designed to acquaint the auxiliary members with the policies and benefits of the MSMA.

Mrs. William R. McPhee
President

At this Conference, 83 auxiliary members joined together to:

(1) become more alert to what is going on within our organization and within the medical profession so that we might be a more knowledgable public relations force and
(2) to focus thinking on the needs of our communities. This is where the real work is done, and it is this involvement that will help lend a positive image.

In such a spirit and with the hope that our membership will assume increased responsibility for the organization by becoming involved in the active circle of planning, the Conference agenda offered both educational and business sessions for the participants.

It was a good conference. "Leadership and learning" was the theme. Enthusiasm was generated. Goals were set. Plans were made. But the true success of such a conference lies in what happens when the participants return home . . . your home. This means homework on their part, demands cooperative effort and cries for sustained motivation to follow through.

We want to make better use of the resources and talents of members of our county auxiliaries, to expand our knowledge, to utilize our abilities and to increase our opportunities. We need your encouragement, your advice and your expertise to make it so.

Will you take time to acknowledge your auxiliary? Will you let the members know you care and that their efforts are visible and valued? Lend your hand and your heart to their activities and include them in your thinking and your plans. It will work wonders. We really do speak for the medical profession. By your side and individually, we help you represent medicine daily.

County Society News

FIRST DISTRICT

COUNCILOR
JOHN N. MARTIN, M.D., ST. JOSEPH

Buchanan County Medical Society

Forty-one St. Joseph and area physicians attended the October 1 meeting of the Buchanan County Medical Society which followed a dinner at the Moila Club.

Howard D. Herrick, M.D., superintendent and regional director for the Norfolk, Neb. Regional Center, was the speaker for the event. He addressed the group on "Recognition and Management of Depressive Illness."

Dr. William B. O'Connor presided at the meeting. Dr. John P. Cox introduced the speaker. Meeting arrangements were made by the Society's program committee of which Dr. Edward H. Andres is chairman and Dr. Robert R. Stuber and Dr. Wallace McDonald are members.

Carl K. Ness, M.D., *Secretary*

Grand River Medical Society

Members of Grand River Medical Society and Auxiliary honored Dr. and Mrs. Willard Ellsworth of Cainsville at a dinner meeting on October 9 at the Chillicothe Country Club.

Dr. Ellsworth, who has practiced medicine for 48½ years, is retiring. He and Mrs. Ellsworth plan to move to Arizona in November.

Mrs. Tom N. Cofer, President of the Auxiliary, presented a corsage to Mrs. Ellsworth and a boutonniere to Dr. Ellsworth. After the dinner, "This Is Your Life" was read by Mrs. Joseph Conrad of Chillicothe.

The Medical Society and Auxiliary held separ business meetings. The Auxiliary members w entertained by the Chillicothe R.S.V.P. memb with marionettes they had made.

Dr. John R. Dixon and Dr. and Mrs. R. W. Bol sack of Brookfield attended the meeting.

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SECOND DISTRICT

COUNCILOR
J. RUSSELL COMER, M.D., HANNIBAL

Chariton-Macon-Monroe-Randolph County Medical Society

The Chariton-Macon-Monroe-Randolph Cour Medical Society held its October meeting and el tion of officers in the library conference room Woodland Hospital in Moberly.

Dr. D. E. Eggleston of Macon was elected Pre dent. Other new officers are Dr. R. L. Bautis Moberly, Vice-President, and Dr. G. R. Huds Moberly, Secretary Treasurer.

Delegates to the MSMA are Dr. F. L. Harn Chariton County; Dr. J. E. Campbell, Mac County; Dr. F. A. Barnett, Monroe County; a Dr. G. R. Hudson, Randolph County.

Alternate Delegates are Dr. D. D. Stuart, D Eggleston, Dr. W. D. Chute and Dr. C. C. Cohrs.

Censors are Dr. D. D. Stuart, Chariton Coun (three years); Dr. J. E. Campbell, Macon Coun (four years); Dr. F. A. Barnett, Monroe Coun (one year); and Dr. W. D. Chute, Randol County (two years).

The program was presented by Dr. William Ne ton, who is Chief of Surgical Services and Direct of Renal Transplant Services at the Veterans A ministration Hospital and Professor of Surgery Washington University School of Medicine in S Louis.

Dr. Newton discussed the kidney transplant pr gram in St. Louis and gave a summary of the hi torical aspects of the early transplant program. H also discussed the uniform anatomical gift act an the criteria for both the living donors and for th use of cadaver donors and covered methods preservation for transplantation prior to transplan

A question-and-answer period followed his pr sentation.

Members who attended the meeting are Dr Antonio Aguilera, Josephine D. Baker, R. L. Ba tista, C. C. Cohrs, J. W. Fleming, Jose Hori, L. Huber, G. R. Hudson, Michael Tan and Robert Tompson of Moberly; F. A. Barnett of Paris; P. Dreyer of Huntsville; F. L. Harms of Salisbury.

Continuing Education Coming Events

Nov. 19	**Seminar in Noninvasive Cardiology: Method of Estimating Cardiac Pump Performance** Depts. of Medicine & Radiology, St. Luke's Hospital and Washington U. Continuing Medical Education St. Luke's Hospital, St. Louis
Nov. 21-22	**The Long Weekend: Infectious Diseases and Intensive Pulmonary Care Workshop** MU-KC School of Medicine, K.C. Southwest Clinical Society and the Academy of Health Professions Crown Center Hotel, Kansas City
Nov. 22	**Semiannual Professional Program: Cancer Detection and Early Diagnosis** Ellis Fischel State Cancer Hospital and Cancer Research Center Hilton Inn, Columbia
Dec. 3	**Postgraduate Seminar: Common Gastrointestinal Disorders** The Ed Bixby Institute for Postgraduate Medical Education Research Medical Center, Kansas City
Dec. 4-5	**Annual Clinical Meeting** Kansas City Society of Ophthalmology and Otolaryngology Plaza Inn, Kansas City
Dec. 4-5	**Symposium: Medical Technology** Division of Continuing Medical Education K.U. Medical Center, Kansas City, Kan.
Dec. 8	**City-Wide Radiologic Conference: Cervical Spine Injuries** Mallinckrodt Institute of Radiology Washington U. School of Medicine, St. Louis
Dec. 11-13	**The Long Weekend—The Heart, 1975** MU-KC School of Medicine Crown Center, Kansas City
Jan. 12	**City-Wide Radiology Conference: New Techniques in Pediatric Radiology** Mallinckrodt Institute of Radiology Washington U. School of Medicine, St. Louis
Jan. 22	**Second Annual Perinatal Symposium** St. Louis U. Medical Center Continuing Education Sesquicentennial Room, Busch Memorial Center, St. Louis

From the Medical Schools

WASHINGTON UNIVERSITY

Charles A. Thomas, Sc.D., was elected Chairman of the Board of Directors for the Washington University Medical Center at the annual meeting in September. The Medical Center includes Barnard Hospital, Barnes Hospital, Central Institute for the Deaf, The Jewish Hospital of St. Louis, St. Louis Children's Hospital and Washington University and its School of Medicine.

Other newly-elected officers are *Harold E. Thayer,* vice-chairman; *Lee M. Liberman,* secretary; and *Thomas Kenton, Jr.,* treasurer. Reelected were *Philip R. Dodge,* M.D., vice-president; *M. Kenton King,* M.D., assistant secretary; and *Hugh Morrison,* assistant treasurer.

Dr. Thomas co-founded Thomas and Hochwalt Laboratories in 1926 in Dayton, Ohio. This company, which specialized in research work for industrial organizations, became Monsanto's Central Research Department in 1936 and Dr. Thomas began a 34-year Monsanto career.

After serving as central research director, he was elected to the Board of Directors in 1942 and served as executive vice-president from 1948 until 1951 when he was elected president and chief executive officer. In 1960, Dr. Thomas was elected Chairman of Monsanto's Board of Directors and served until 1965.

At the meeting, *Samuel B. Guze,* M.D., president of Washington University Medical Center, praised the efforts of *Raymond E. Rowland* who had served three years as the Chairman of the Board for the Medical Center.

Dr. Guze also presented the annual report disclosing that Medical Center institutions had given more than $5.7 million of free care during the past year while completing construction and renovations in excess of $16.7 million.

The focus of the President's report was on activities and events which exemplify the range of services, research and teaching programs at the Medical Center.

The Allen P. and Josephine B. Green Professorship in Pediatric Neurology, the first such chair in the country, has been established at the School of Medicine.

Arthur L. Prensky, M.D., professor of pediatr and of neurology and director of the Division Pediatric Neurology, St. Louis Children's Hospi has been named to the post. The announcem was made recently by *Philip R. Dodge,* M.D., p fessor of pediatrics and of neurology, who is he of the Edward Mallinckrodt Department of Pe atrics and medical director at St. Louis Childre Hospital.

Dr. Dodge expressed gratitude for the generos of the Green Foundation. He noted the half-m lion dollar endowment establishing the profess ship was one of many gifts to the Washingt University School of Medicine and St. Louis Ch dren's Hospital by the Foundation over the l decade to facilitate research, service and teachi in pediatric neurology.

Dr. Prensky received the M.D. degree in 19 from the New York University College of Me cine. He has been associated with St. Louis Ch dren's Hospital and the School of Medicine sin 1967. He was formerly an assistant in neurolo at Massachusetts General Hospital and instruct at the Harvard Medical School attached to t Joseph P. Kennedy, Jr., Memorial Laboratories f the Study of Mental Retardation, Boston.

Dr. Prensky currently is studying the flow of gl cose carbon into amino acids and lipids in the d veloping brain during disease and the recove from nonspecific neonatal insults, such as starv tion.

UNIVERSITY OF MISSOURI-COLUMBIA

Dr. James O. Davis, chairman of the Departme of Physiology at the School of Medicine, has r ceived a gold medallion and citation from th American Heart Association's Council for Hig Blood Pressure Research. The award also carries cash prize of $5,000 given by CIBA Pharmaceutic Co. for his work toward a greater understandin of hypertension.

Dr. Davis shares honors with two other scientist for their research in the field of high blood pressure They are *Lewis K. Dahl,* M.D., senior scientis

Brookhaven National Laboratory in Upton, N.Y.,
d *Walter Kempner,* M.D., professor emeritus of
edicine, Duke University Medical Center, Dur-
m, N. C.

Dr. Davis was recognized for his discovery of the
echanisms that control the secretion of the salt-
taining hormone, aldosterone, and for his research
the control of renin release of the kidney. In
s career, he has published nearly 200 articles re-
ting to studies of heart disease.

Dr. Dahl was cited for his studies of the role of
dium chloride in human hypertension and in an
perimental animal model in which there are sen-
izing, genetic and renal factors.

Dr. Kempner was given the award for his docu-
entation in man of the value of rice and a low
dium diet which by itself can arrest or control
gh blood pressure and its consequences.

The three men were chosen by a selection com-
ittee of eight internationally-known scientists.
rmal presentation of the awards was made at the
nual meeting of the Council for High Blood
essure Research in Cleveland on October 10.

Dr. Davis received his B.S. in Medicine degree
m the University of Missouri when it had only
two-year medical school and then completed his
nical training for the M.D. degree from Wash-
gton University in St. Louis in 1945. He received
Ph.D. degree in zoology from Missouri in 1942.

In 1947 he worked as an investigator in the sec-
n on gerontology and cardiovascular diseases at
e National Institutes of Health and later became
investigator in the laboratory of the kidney and
etrolyte metabolism at the National Heart In-
tute. In 1966, he was appointed professor and
airman of the department of physiology at the
iversity of Missouri.

The Missouri Office of Comprehensive Health
anning has involved several members of the
hool of Medicine faculty in developing programs
mandated by Public Law 93-641.

Dr. W. D. Mayer, representing the Missouri Re-
nal Medical Program, has served on a task force
pointed by Gov. Christopher Bond to make
commendations concerning designated Health
rvice Areas of the state.

Five regions have been established. *Dr. James
xter,* assistant dean, is chairman of an advisory
oup assisting a task force in developing a state
kage system for health manpower planning. Dr.
xter's group includes *Dr. Richard Wallace* and
Stuart Wesbury of the Health Services Man-
ement faculty, *Dr. Daryl Hobbs* and *Stuart Plot-
k,* a student in the HSM graduate program.

ST. LOUIS UNIVERSITY

Three major appointments have been made at the St. Louis University Medical Center by *Dr. George E. Thoma,* vice-president for the Medical Center.

Dr. Eli M. Nadel has been named assistant vice-president for Medical Center Research at the Medical Center and will direct a cancer program.

Dr. Nadel

In his new post, Dr. Nadel will hold the rank of full professor of pathology at the School of Medicine. He comes from the Medical University of South Carolina in Charleston, where he has been professor of pathology, associate dean and chief-of-staff at the Veterans Administration Hospital since 1972.

When the Cancer Program award was received several months ago, Dr. Thoma explained that the total thrust of the new program will be to determine if a Cancer Center can be developed at St. Louis University and what role the Center can play in a comprehensive cancer center for the state of Missouri.

At that time, he said that the grant would enable the Center to develop and utilize a plan for the acquisition of staff, installation of new facilities and the encouragement and initiation of more fully integrated basic and clinical programs.

Dr. Richard J. Dames, assistant dean of the School of Medicine, has been named assistant to the Vice-President for the St. Louis University Medical Center.

Dr. Dames

Dr. Thoma said that Dr. Dames's main area of responsibility will be alumni affairs. He added that the appointment is on a part-time basis, and that Dr. Dames plans to continue his private practice as an internist.

Dr. Thoma cited Dr. Dames's leadership as a liaison man with the Medical Alumni Association over the years. As assistant dean since 1965, Dr. Dames handled financial aid for medical students, was director of the internship and residency programs for the St. Louis Uni-

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Choloxin® (sodium dextrothyroxine)

The Lipid-Lowering Agent with Once-A-Day Dosage

Four strengths . . . 1, 2, 4, and 6 mg. . . . are available making the scored tablet regimen a flexible dosage system. And, for most patients, CHOLOXIN tablets offer once-a-day dosage.

AN IMPORTANT NOTE:
It has not been established whether the drug-induced lowering of serum cholesterol or lipid levels has a detrimental, beneficial, or no effect on the morbidity or mortality due to atherosclerosis or coronary heart disease. Several years will be required before current investigations will yield an answer to this question.

CHOLOXIN® (sodium dextrothyroxine) Single-Tablet-A-Day Dosage Schedules

See prescribing information in package insert reproduced below.

	Starting Dosage	Increased Monthly by	Usual Maintenance	Maximal Recommended
Adult Hypercholesterolemic	1.0-2.0 mg.	1.0-2.0 mg.	4.0-8.0 mg.	4.0-8.0 mg.
Pediatric Hypercholesterolemic	0.05 mg./kg. body weight	0.05 mg./kg.	0.1 mg./kg. body weight	4.0 mg.
Hypothyroid Cardiac	0.5-1.0 mg.	1.0 mg.	4.0 mg.	4.0 mg.

Choloxin®
(sodium dextrothyroxine)

Description
CHOLOXIN (sodium dextrothyroxine) is the sodium salt of the dextrorotatory isomer of thyroxine. It is chemically described as D-3,5,3′,5′-tetraiodothyronine sodium salt.

Actions
The predominant effect of CHOLOXIN (sodium dextrothyroxine) is the reduction of serum cholesterol levels in hyperlipidemic patients. Beta lipoprotein and triglyceride fractions may also be reduced from previously elevated levels.

Most of the available evidence indicates that CHOLOXIN stimulates the liver to increase catabolism and excretion of cholesterol and its degradation products via the biliary route into the feces. Cholesterol synthesis is not inhibited and abnormal metabolic end-products do not accumulate in the blood.

Indications
This is not an innocuous drug. Strict attention should be paid to the indications and contraindications.

CHOLOXIN (sodium dextrothyroxine) is an antilipidemic agent used as an adjunct to diet and other measures for the reduction of elevated serum cholesterol (low density lipoproteins) in euthyroid patients with no known evidence of organic heart disease.

The drug is also indicated in the treatment of hypothyroidism in patients with cardiac disease who cannot tolerate other types of thyroid medication.

Before prescribing, note the following: Results from a randomized clinical study have indicated a possible adverse effect when CHOLOXIN is administered to a patient receiving a digitalis preparation. There may be an additive effect. This additive effect may possibly stimulate the myocardium excessively in patients with significant myocardial impairment. CHOLOXIN dosage should not exceed 4 mg per day when the patient is receiving a digitalis preparation concomitantly. Careful monitoring of the total effect of both drugs is important.

It has not been established whether the drug-induced lowering of serum cholesterol or lipid levels has a detrimental, beneficial, or no effect on the morbidity or mortality due to atherosclerosis or coronary heart disease. Several years will be required before current investigations will yield an answer to this question.

Contraindications
The administration of CHOLOXIN (sodium dextrothyroxine) to euthyroid patients with one or more of the following conditions is contraindicated:

1. Known organic heart disease, including angina pectoris; history of myocardial infarction; cardiac arrhythmia or tachycardia, either active or in patients with demonstrated propensity for arrhythmias; rheumatic heart disease; history of congestive heart failure; and decompensated or borderline compensated cardiac status.
2. Hypertensive states (other than mild, labile systolic hypertension).
3. Advanced liver or kidney disease.
4. Pregnancy.
5. Nursing mothers.
6. History of iodism.

Warnings
CHOLOXIN (sodium dextrothyroxine) may potentiate the effects of anticoagulants on prothrombin time. Reductions of anticoagulant dosage by as much as 30% have been required in some patients. Consequently, the dosage of anticoagulants should be reduced by one-third upon initiation of CHOLOXIN therapy and the dosage subsequently readjusted on the basis of prothrombin time. The prothrombin time of patients receiving anticoagulant therapy concomitantly with CHOLOXIN therapy should be observed as frequently as necessary, but at least weekly, during the first few weeks of treatment.

In the surgical patient, it is wise to consider withdrawal of the drug two weeks prior to surgery if the use of anticoagulants during surgery is contemplated.

When CHOLOXIN is used as thyroid replacement therapy in hypothyroid patients with concomitant coronary artery disease (especially those with a history of angina pectoris or myocardial infarction) or other cardiac disease, treatment should be initiated with care. Special consideration of the dosage schedule of CHOLOXIN is required. This drug may increase the oxygen requirements of the myocardium, especially at high dosage levels. Treated subjects with coronary artery disease must be seen at frequent intervals. If aggravation of angina or increased myocardial ischemia, cardiac failure, or clinically significant arrhythmia develops during the treatment of hypothyroid patients, the dosage should be reduced or the drug discontinued.

Special consideration must be given to the dosage of other thyroid medications used concomitantly with CHOLOXIN. As with all thyroactive drugs, hypothyroid patients are more sensitive to a given dose of CHOLOXIN than euthyroid patients.

Epinephrine injection in patients with coronary artery disease may precipitate an episode of coronary insufficiency. This condition may be enhanced in patients receiving thyroid analogues. These phenomena should be kept in mind when catecholamine injections are required in sodium dextrothyroxine-treated patients with coronary artery disease.

Since the possibility of precipitating cardiac arrhythmias during surgery may be greater in patients treated with thyroid hormones, it may be wise to discontinue CHOLOXIN in euthyroid patients at least two weeks prior to an elective operation. During emergency surgery in euthyroid patients, and in surgery in hypothyroid patients in whom it may be advisable to withdraw therapy, the patients should be carefully observed.

There are reports that sodium dextrothyroxine in diabetic patients is capable of increasing blood sugar levels with a resultant increase in requirements of insulin or oral hypoglycemic agents. Special attention should be paid to parameters necessary for good control of the diabetic state in dextrothyroxine-treated subjects and to dosage requirements of insulin or other antidiabetic drugs. If sodium dextrothyroxine is later withdrawn from patients who had required an increase of insulin (or oral hypoglycemic agents) dosage during its administration, the dosage of antidiabetic drugs should be reduced and adjusted to maintain good control of the diabetic state.

When either or both impaired liver or kidney function are present, the advantages of CHOLOXIN therapy must be weighed against the possibility of deleterious results.

Usage in Women of Childbearing Age
Women of childbearing age with familial hypercholesterolemia or hyperlipemia should not be deprived of the use of this drug; it can be given to those patients exercising strict birth control procedures. Since pregnancy may occur despite the use of birth control procedures, administration of CHOLOXIN (sodium dextrothyroxine) to women of this age group should be undertaken only after weighing the possible risk to the fetus against the possible benefits to the mother. Teratogenic studies in two animal species have resulted in no abnormalities in the offspring.

Precautions
It is expected that patients on dextrothyroxine therapy will show greatly increased serum protein-bound-iodine levels. These increased serum PBI values are evidence of absorption and transport of the drug, and should NOT be interpreted as evidence of hypermetabolism; similarly, they may not be used for titrating the effective dose of CHOLOXIN (sodium dextrothyroxine). PBI values in the range of 10 to 25 mcg% in treated patients are common.

If signs or symptoms of iodism develop during CHOLOXIN therapy, the drug should be discontinued.

A few children with familial hypercholesterolemia have been treated with CHOLOXIN for periods of one year or longer with no adverse effects on growth. However, it is recommended that the drug be continued in patients in this age group only if a significant serum cholesterol-lowering effect is observed.

Adverse Reactions
The side effects attributed to dextrothyroxine therapy are, for the most part, due to increased metabolism, and may be minimized by following the recommended dosage schedule. Adverse effects are least commonly seen in euthyroid patients with no signs or symptoms of organic heart disease; the incidence of adverse effects is increased in hypothyroid patients, and is highest in those patients with organic heart disease superimposed on the hypothyroid state.

In the absence of known organic heart disease, some cardiac changes may be precipitated during sodium dextrothyroxine therapy. In addition to angina pectoris, arrhythmia consisting of extrasystoles, ectopic beats, or supraventricular tachycardia, ECG evidence of ischemic myocardial changes and increase in heart size have been observed. Myocardial infarctions, both fatal and non-fatal, have occurred, but these are not unexpected in untreated patients in the age groups studied. It is not known whether any of these infarcts were drug related.

Changes in clinical status that may be related to the metabolic action of the drug include the development of insomnia, nervousness, palpitations, tremors, loss of weight, lid lag, sweating, flushing, hyperthermia, hair loss, diuresis, and menstrual irregularities. Gastrointestinal complaints during therapy have included dyspepsia, nausea and vomiting, constipation, diarrhea, and decrease in appetite.

Other side effects reported to be associated with CHOLOXIN (sodium dextrothyroxine) therapy include the development of headache, changes in libido (increase or decrease), hoarseness, tinnitus, dizziness, peripheral edema, malaise, tiredness, visual disturbances, psychic changes, paresthesia, muscle pain, and various bizarre subjective complaints. Skin rashes, including a few which appeared to be due to iodism, and itching have been attributed to dextrothyroxine by some investigators. Gallstones have been discovered in occasional dextrothyroxine-treated patients and cholestatic jaundice has occurred in one patient, although its relationship to CHOLOXIN therapy was not established.

In several instances, the previously existing conditions of the patient appeared to continue or progress during the administration of CHOLOXIN; a worsening of peripheral vascular disease, sensorium, exophthalmos, and retinopathy have been reported.

CHOLOXIN potentiates the effects of anticoagulants, such as warfarin or Dicumarol, on prothrombin time, thus indicating a decrease in the dosage requirements of the anticoagulants. On the other hand, dosage requirements of antidiabetic drugs have been reported to be increased during dextrothyroxine therapy (see WARNINGS section).

Dosage and Administration
For **adult** euthyroid hypercholesterolemic patients, the recommended maintenance dose of CHOLOXIN (sodium dextrothyroxine) is 4 to 8 mg per day. The initial daily dose should be 1 to 2 mg to be increased in 1 to 2 mg increments at intervals of not less than one month to a maximum level of 4 to 8 mg daily, if that dosage level is indicated to effect the desired lowering of serum cholesterol.

When used as partial or complete substitution therapy for levothyroxine in hypothyroid patients with cardiac disease who cannot tolerate other types of thyroid medication, the initial daily dose should be 1 mg to be increased in 1 mg increments at intervals of not less than one month to a maximum level of 4 to 8 mg daily, preferably the lower dosage. The maximum in patients receiving digitalis therapy is 4 mg.

For **pediatric** hypercholesterolemic patients, the recommended maintenance dose of CHOLOXIN is approximately 0.1 mg per kilogram. The initial daily dosage should be approximately 0.05 mg per kilogram to be increased in up to 0.05 mg per kilogram increments at monthly intervals. The recommended maximal dose is 4 mg daily, if that dosage is indicated to effect the desired lowering of serum cholesterol.

If new signs or symptoms of cardiac disease develop during the treatment period, the drug should be withdrawn.

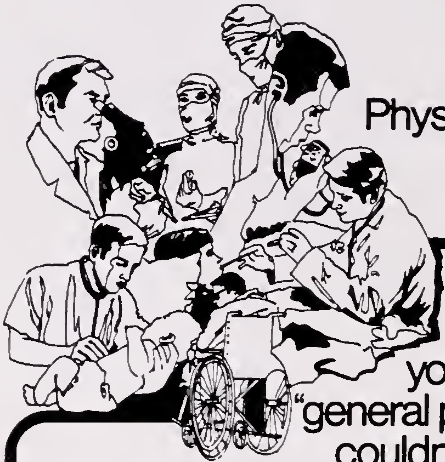
How Supplied
CHOLOXIN (sodium dextrothyroxine) is supplied in prescription packages of scored 1, 2, 4, and 6 mg tablets.

FLINT LABORATORIES
DIVISION OF TRAVENOL LABORATORIES INC
Deerfield, Illinois 60015

versity Hospitals and has served as a member of the Admissions Committee at the School of Medicine since 1964. He assisted the dean of the School of Medicine in other administrative matters. He is serving as a member of the committee on Medical Education of the Missouri State Medical Association.

Dr. Manuel R. Comas, associate professor of gynecology and obstetrics, has been named assistant dean for students at the School of Medicine. He will assume some of the administrative duties formerly performed by Dr. Dames. From 1966 to 1970, Dr. Comas was project gynecologist and administrator of a USPHS grant titled "The Cytological and Clinical Detection of Cervical Cancer in an Unscreened Population" for the city of St. Louis and St. Louis City Hospital. He has staff privileges at the St. Louis University Hospitals, St. Mary's Health Center and St. Louis City Hospital.

Dr. Comas



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UNIVERSITY OF MISSOURI-KANSAS CITY

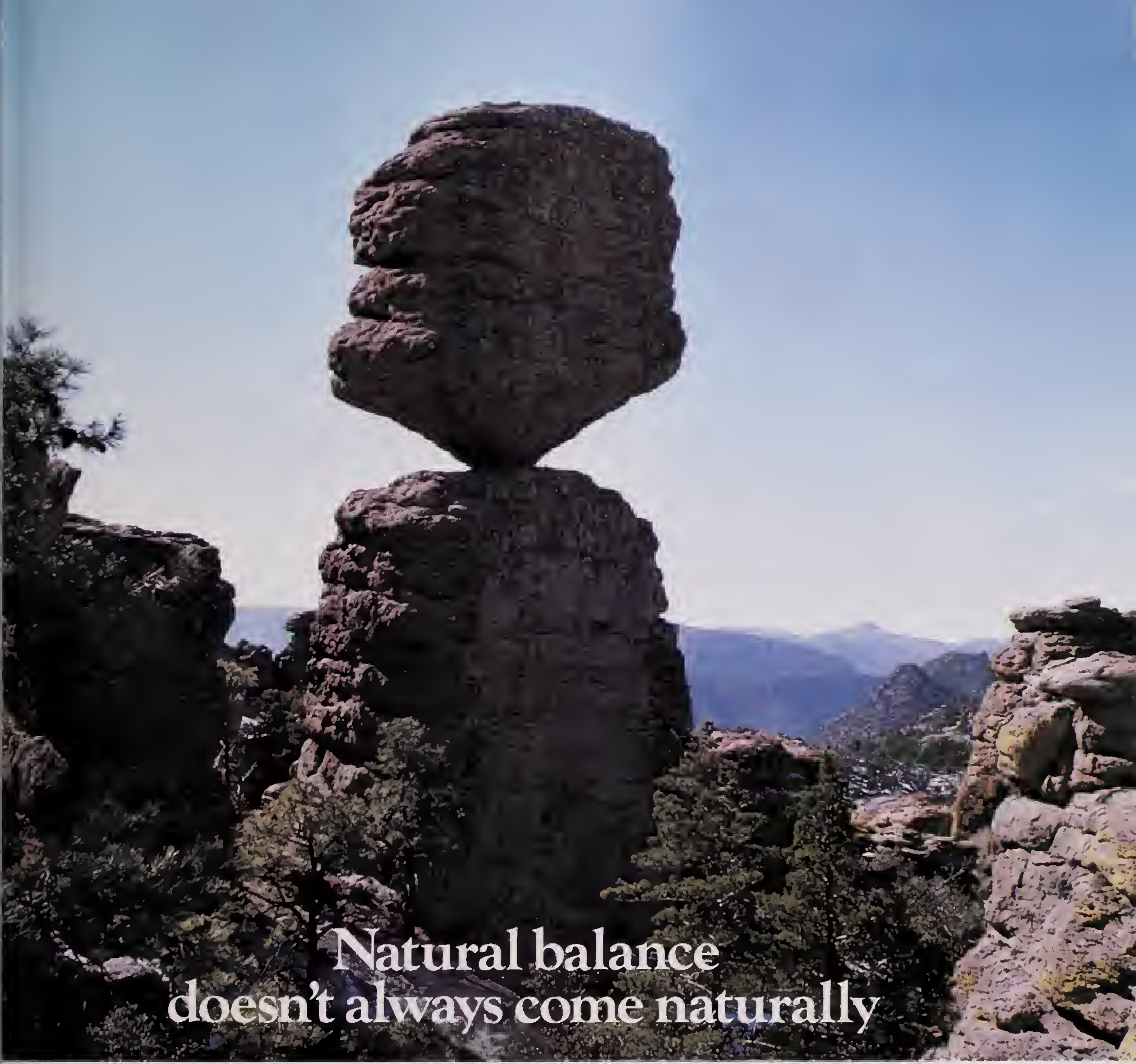
The American College of Cardiology, in coo eration with the UMKC Office of Health Scienc presented a ten-day course on "Cardiology for t Consultant" at the School of Medicine in Octob The course has been presented for a number years in Rancho Santa Fe, Calif. under the spo sorship of *Provost E. Grey Dimond.* A limite enrollment of physicians from all over the U. and Canada attended the meeting. Many had a tended the previous conferences. The faculty co sisted of members of the UMKC School of Med cine faculty, in addition to cardiology specialis from several U. S. medical centers.

The faculty of the Department of Chemist of the College of Arts and Sciences has sever new members who teach UMKC medical studen as well as the arts and sciences students.

Dr. Carol M. Greenspan is an assistant profe sor who earned her Ph.D. degree at the College Physicians and Surgeons at Columbia University *Dr. Anthony John Hancock* also is an assistant pr fessor. He received his Ph.D. degree in chemistr at the University of Ottawa in 1972. *Dr. Kennet Stanley Schmitz,* an assistant professor, earned hi Ph.D. degree from the University of Washington *Dr. James Schaeffer,* an assistant professor in Bio organic Chemistry, received his Ph.D. degree from the University of California in 1971. *Dr. In-y Yang,* an assistant professor, earned his Ph.D. de gree in Biochemistry from Iowa State University.

These new chemistry faculty members hav helped strengthen the basic sciences offerings o the School of Medicine as well as the College o Arts and Sciences. A part of their teaching responsibility will be to provide three-month courses t accommodate the scheduling of the medical school.

Two Visiting Docents taught at the School of Medicine in September. *James W. Linman,* M.D., head of the Division of Hematology and professor of medicine at the University of Oregon, visited on September 8-13. During that time, he gave the University Hour presentation on "Sideroblastic Anemia." *Lemuel W. Diggs,* M.D., was a visiting docent on September 18-20. Dr. Diggs is Goodman Professor of Medicine Emeritus, University of Tennessee School of Medicine. His University Hour presentation was "50 Years in Hematology." Both of these visiting docents made rounds and gave special lectures to medical students as well as prepared audio-visual materials to be used in the UMKC School of Medicine audio-visual library.



Big Balanced Rock, Chiricahua Mountains, Arizona (approx. 1,000 tons)

und useful in the management of vertigo* associated with ases affecting the vestibular system.

n relieve nausea and vomiting often associated with vertigo.*

sual adult dosage for Antivert/25 for vertigo:* one tablet t.i.d.

so available as Antivert (meclizine HCl) 12.5 mg. scored ts, for dosage convenience and flexibility.

ntivert/25 (meclizine HCl) 25 mg. *Chewable* Tablets for ea, vomiting and dizziness associated with motion sickness.

SUMMARY OF PRESCRIBING INFORMATION

DICATIONS. Based on a review of this drug by the National Academy of nces—National Research Council and/or other information, FDA has classified indications as follows:

ffective: Management of nausea and vomiting and dizziness associated with ion sickness.

ossibly Effective: Management of vertigo associated with diseases affecting the ibular system.

inal classification of the less than effective indications requires further stigation.

CONTRAINDICATIONS. Administration of Antivert (meclizine HCl) during pregnancy or to women who may become pregnant is contraindicated in view of the teratogenic effect of the drug in rats.

The administration of meclizine to pregnant rats during the 12-15 day of gestation has produced cleft palate in the offspring. Limited studies using doses of over 100 mg./kg./day in rabbits and 10 mg./kg./day in pigs and monkeys did not show cleft palate. Congeners of meclizine have caused cleft palate in species other than the rat.

Meclizine HCl is contraindicated in individuals who have shown a previous hypersensitivity to it.

WARNINGS. Since drowsiness may, on occasion, occur with use of this drug, patients should be warned of this possibility and cautioned against driving a car or operating dangerous machinery.

Usage in Children: Clinical studies establishing safety and effectiveness in children have not been done; therefore, usage is not recommended in the pediatric age group.

Usage in Pregnancy: See "Contraindications."

ADVERSE REACTIONS. Drowsiness, dry mouth and, on rare occasions, blurred vision have been reported.

More detailed professional information available on request.

ROERIG Pfizer
A division of Pfizer Pharmaceuticals
New York, New York 10017

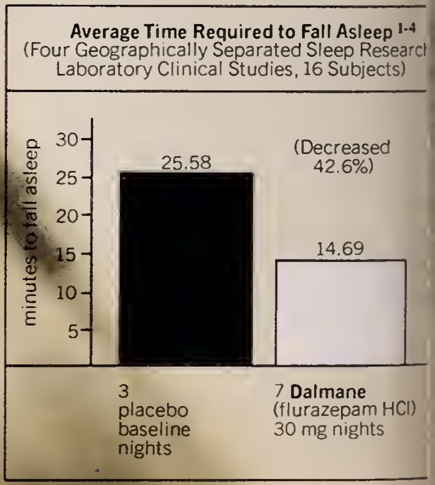
Antivert®/25
(meclizine HCl) 25 mg. Tablets
for vertigo*

How do you handle trouble falling asleep?

AWAKE
HOURS
1
2

With Dalmane® (flurazepam HCl), results are highly predictable.

As demonstrated below, Dalma induces sleep within 17 minutes, o average:[1-4]



**nd for those with trouble
ang asleep or sleeping
n enough…**
sleep research laboratory
ral studies prove: Dalmane
cases number of nighttime
venings and increases total
ed time.[5]

**lmane (flurazepam HCl)
ratively safe, seldom
es morning "hang-over"**
Ilmane is generally well
ated. The usual adult dose of
ig should initially be lowered to
rg for the elderly and
bitated, to help preclude
eedation, dizziness or ataxia.
aisal of possible risks is
gested before prescribing.

RENCES:

can I, Williams RL, Smith JR:
eep laboratory in the investigation
slp and sleep disturbances. Scientific
t at the 124th annual meeting of the
can Psychiatric Association,
sngton DC, May 3-7, 1971

st JD Jr: A system for automati-
nalyzing sleep. Scientific exhibit at
h annual Clinical Convention of the
can Medical Association, Boston,
-Dec 2, 1970; and at the 42nd
l scientific meeting of the Aerospace
dal Association, Houston, Apr 26-29,

el GW: Data on file, Medical Depart-
n Hoffmann-La Roche Inc., Nutley NJ

ent WC: Data on file, Medical
ptment, Hoffmann-La Roche Inc.,
NJ

a on file, Medical Department,
ann-La Roche Inc., Nutley NJ

**prescribing Dalmane (flurazepam
please consult complete product
ation, a summary of which follows:**

tions: Effective in all types of insomnia terized by difficulty in falling asleep, nt nocturnal awakenings and/or early ng awakening; in patients with recurring nia or poor sleeping habits; and in or chronic medical situations requiring sleep. Since insomnia is often transient termittent, prolonged administration is lly not necessary or recommended.

Contraindications: Known hypersensitivity to flurazepam HCl.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. Caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Use in women who are or may become pregnant only when potential benefits have been weighed against possible hazards. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated, initial dosage should be limited to 15 mg to preclude oversedation, dizziness and/or ataxia. If combined with other drugs having hypnotic or CNS-depressant effects, consider potential additive effects. Employ usual precautions in patients who are severely depressed, or with latent depression or suicidal tendencies. Periodic blood counts and liver and kidney function tests are advised during repeated therapy. Observe usual precautions in presence of impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported were headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins and alkaline phosphatase. Paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity, have also been reported in rare instances.

Dosage: Individualize for maximum beneficial effect. *Adults:* 30 mg usual dosage; 15 mg may suffice in some patients. *Elderly or debilitated patients:* 15 mg initially until response is determined.

Supplied: Capsules containing 15 mg or 30 mg flurazepam HCl.

You can
depend on the
efficacy of

Dalmane®
(flurazepam HCl)

**One 30-mg capsule *h.s.*— usual adult dosage
(15 mg may suffice in some patients).
One 15-mg capsule *h.s.*— initial dosage for
elderly or debilitated patients.**

for insomnia

Objectively proved in the sleep research laboratory:
- **sleep within 17 minutes, on average**
- **sleep with fewer nighttime awakenings**
- **sleep for 7 to 8 hours, on average,**

with a single *h.s.* dose

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Opinion & Dialogue

Should a specially prepared package insert be made available to patients?

Dr. Alexander M. Schmidt
Commissioner,
Food and Drug
Administration

The idea of a so-called pa package insert has been arou a long time. Many physicians use written instruction sheets provide patients with informat about the drugs they are takin some physicians give verbal ir tions; but in too many instanc these are what I call eye-glazir ercises. I have seen patients si glazed eyes listening to a rapic lecture by a hurried physician has 20 people out in his waitin room. These patients aren't gi sufficient understanding and t fore do not follow instructions. think the idea of an official pac insert for patients is a good on Perhaps we should really think this kind of information simply extension of drug labeling.

The benefits of patient involven

Many physicians may not ize how frequently a patient ob his drug information from Aur Tillie or the next door neighbor this information is almost alw bad or irrelevant to the case at Furthermore, the incentive to along with a prescribed progra slim if the only reading matter patient receives, along with his scription, is a bill.

As an educator I am impr by the principle that the best w get someone to do something is involve him in the process. So t

Dr. James H. Sammons
Executive Vice President
of the American
Medical Association

I think there are advantag well as some real disadvantage a patient package insert. When begin to use semi-medical or m cal terms to describe complicat or possible sequelae of disease treatment, you may frighten the tient—particularly since the mo highly sophisticated patient is the one who is going to read the sert. The patient who will read it the one most susceptible to frig and confusion by the language.

On the positive side, a pac insert will probably give the pati better insight into why he is beir treated the way he is, and it ma give the physician a little bit mo time. But it does not remove fro the physician the need or obliga to explain the insert.

Some pitfalls in the inclusion of side effects

Certainly a patient should warned of the possibility of seric side reactions—to know what th real dangers are. But it doesn't bit of good to indicate that a pat on oral penicillin may develop a rash, itching, or a drop in blood pressure. Or that he may faint. I think the real danger is that frig engendered by the insert may pc sibly outweigh the potential gooc

purpose of drug information
e patient is to get his coopera-
n following a drug regimen.

ration and distribution of nt drug information

We would hope to amass infor-
on from physicians, medical
ties, the pharmaceutical indus-
d centers of medical learning.
ltimate responsibility for uni-
labeling must, however, rest
he Food and Drug Administra-
There is nothing wrong with
gency saying, "this informa-
s generally agreed upon and
fore it should be used," as long
r process for getting the infor-
n is sound.

Distribution of the information
roblem. In great measure it
depend on the medication in
ion. For example, in the case
injectable long-acting proges-
e, we would think it mandatory
ue two separate leaflets—a
one for the patient to read be-
etting the first shot and a long
take home in order to make a
ion about continuing therapy.
s case, the information might
t directly on the package and
movable at all. But for a medi-
like an antihistamine this
nation might be issued sepa-
, thus giving the physician the
of distribution. This could
rve the placebo use, etc.

It is in the distribution of patient information that the pharmacist may get involved. As professionals and members of the health-care team and as a most important source of drug information to patients, pharmacists should be responsible for keeping medical and drug records on patients. It is also logical that they should distribute drug information to them.

Realistic problems must be considered

We have to expect that the introduction of an information device will also create new problems. First, how can we communicate complex and sophisticated information to people of widely divergent socioeconomic and ethnic groups? Second, what will we say? And third, how can we counteract the negative attitude of many physicians toward any outside influence or input? Hopefully the medical profession will respond by anticipating the problems and helping to solve them. Assuming we can also solve the difficulty of communicating information to diverse groups throughout the United States, our remaining task will be the inclusion of appropriate material.

What information is appropriate?

In my opinion, technical, chemical and such types of material should not be included. And there is no point in the routine listing of side effects like nausea and vomiting which seem to apply to practically all drugs, unless it is common with the drug. However, serious side effects should be listed, as should information about a medication that is potentially risky for other reasons.

Other pertinent information might consist of drug interactions, the need for laboratory follow-up, and special storage requirements. What we want to include is information that will help increase patient compliance with the therapy.

Positive aspects of patient drug information

Labeling medication for the patient would accomplish a number of good things: the patient could be on the lookout for possible serious side effects; his compliance would increase through greater understanding; the physician would be a better source of information since he would be freer to use his time more effectively; other members of the health-care team would benefit through patient understanding and cooperation; and, finally, the physician-patient relationship would probably be enhanced by the greater understanding on the part of the patient of what the physician is doing for him.

---

he doctor can remove that fear
or 30 minutes of conversation.
'm not suggesting that we
old any information from the
nt because, first of all, it would
ally dishonest and secondly, it
defeat the very purpose of the
. I do think that a patient on the
control pill should know about
cidence of phlebothrombosis.
f you're going to tell a patient
cidence of serious adverse re-
ns, then you have to tell him
concerned medical decision
nade to use a particular medi-
in his situation after careful
deration of the incidence of
lications or side effects.

onally unstable patients pose cial problem

There are patients who, be-
of severe emotional problems,
not handle the information
ined in a patient package in-
Yet if we are going to have a
ge insert at all, we just can't
two inserts. I think we might
y have to tell the families of
patients to remove the insert
the package.

implications of the patient ge insert

Just what effect would a patient package insert have on malpractice? We could try to avoid any legal implications by pointing out that the physician has selected a particular medication because, in his professional judgment, it is the treatment of choice. For instance, you can't tell everyone taking antihistamines not to work just because a few patients develop extreme drowsiness which can lead to accidents. And what about the very small incidence of aplastic anemia rarely associated with chloramphenicol? If, based on sensitivity studies and other criteria, we decide to employ this particular antibiotic, we do so in full knowledge of this serious potential side effect. It's not a simple problem.

How do we handle an insert for medication used for a placebo effect?

With rare exceptions, physicians no longer use medications for a placebo effect. This question does raise the issue of how a patient may react to receiving a medication without a package insert.

Preparation of the package insert

The development of the insert ought to be a joint operation between physicians, the pharmaceutical industry, the A.M.A. and the F.D.A.

I view the A.M.A.'s role as a coordinator or catalyst. It is the only organization through which the profession as a whole, irrespective of specialty, can speak. It has relatively instant access to all the medical expertise in this country. And it can bring that professional expertise together to ensure a better package insert. The A.M.A. can work in conjunction with the industry that has produced the product and which is ultimately going to supply the insert.

I don't think we should rely, or expect to rely, on legislative committees and their nonprofessional staffs to make these decisions when it is perfectly within the power of the two groups to resolve the issues in the very best American tradition—without the government forcing us to do it. I think the F.D.A. has to be involved, but I'd like them to become involved because they were asked to become involved.

Pharmaceutical
Manufacturers Association
1155 Fifteenth Street, N.W.
Washington, D.C. 20005

P·M·A

New Members

Trinidad J. A. Aguilera, M.D., Moberly Medical Clinic, Moberly 65270, has become a member of St. Louis Medical Society. Dr. Aguilera is a native of Paraguay, received his preliminary education at National University of Asuncion and his M.D. degree at National University of Asuncion in 1963. He specializes in general surgery.

Robert L. Becker, M.D., 2821 N. Ballas Rd., Creve Coeur 63141, has become a member of St. Louis County Medical Society. Dr. Becker is a native of St. Louis, received his preliminary education at Cornell University and his M.D. degree at Washington University in 1969. He specializes in obstetrics and gynecology.

Joseph C. Evans, Jr., M.D., 1515 W. Truman Rd., Independence 64050, has become a member of Jackson County Medical Society. Dr. Evans is a native of Richmond Heights, received his preliminary education at Washington University and his M.D. degree at the University of Missouri in 1970. He specializes in general surgery.

John C. Hagan, III, M.D., 2700 Hospital Drive, N. Kansas City 64116, has become a member of Clay County Medical Society. Dr. Hagan is a native of Mexico, received his preliminary education at the University of Missouri and his M.D. degree at Loyola Strich Medical School in 1969. He specializes in ophthalmology.

Ernest J. Hanson, Jr., M.D., 4320 Wornall Rd., Kansas City 64111, has become a member of Jackson County Medical Society. Dr. Hanson is a native of Cheyenne, Wyo., received his preliminary education at the University of North Dakota and his M.D. degree at the University of Pennsylvania in 1969. He specializes in neurosurgery.

Robert L. Hawley, M.D., 2411 Holmes, Kansas City 64108, has become a member of Jackson County Medical Society. Dr. Hawley is a native of Cincinnati, Ohio, received his preliminary education at George Washington University and his M.D. degree at the University of Colorado in 1951. He specializes in pathology and cardiology.

Larry V. Hays, M.D., 4320 Wornall Rd., Kansas City 64111, has become a member of Jackson County Medical Society. Dr. Hays is a native of St. Joseph, received his preliminary education at Kansas University and his M.D. degree at Kansas University in 1970. He specializes in surgery.

Rizk M. Hemaya, M.D., 600 E. 22nd, Kansas C
64108, has become a member of Jackson Cou
Medical Society. Dr. Hemaya is a native of Egy
received his M.D. degree at Ain Shams Univers
in 1952. He specializes in psychiatry.

Joseph E. Henry, M.D., 2700 Hospital I
N. Kansas City 64116, has become a member
Clay County Medical Society. Dr. Henry is a nat
of Lyons, Kan., received his preliminary educati
at Kansas State Teachers College and his M.D.
gree at Kansas University in 1968. He speciali
in internal medicine.

Oscar O. Isidoro, M.D., 938 Masterson, Kenn
63857, has become a member of Dunklin Cour
Medical Society. Dr. Isidoro is a native of Mani
Philippines, received his preliminary education
the University of the East and his M.D. degree
the University of the East in 1967. He specializ
in radiology.

Aurora G. Kellogg, M.D., 24th at Gillham R
Kansas City 64108, has become a member of Jac
son County Medical Society. Dr. Kellogg is a nati
of the Philippines, received his preliminary educ
tion at the University of Santo Tomas and
M.D. degree at the University of Santo Tomas
1962. He specializes in anesthesiology.

Myo M. Kyaw, M.D., 105 Northland Medic
Bldg., St. Louis 63136, has become a member
St. Louis County Medical Society. Dr. Kyaw is
native of Insein, Burma, received his prelimina
education at Baylor University and his M.D. d
gree at St. Louis University in 1963. He specializ
in diagnostic radiology.

In Kook Lee, M.D., 205 Elm, Washington 6309
has become a member of Franklin-Gasconad
Warren County Medical Society. Dr. Lee is a nati
of Seoul, Korea, received his preliminary educa
tion at Yonsei University and his M.D. degree
Yonsei University in 1965. He specializes in o
stetrics and gynecology.

Lynn R. McCanse, M.D., 4320 Wornall Rd
Kansas City 64111, has become a member of Jack
son County Medical Society. Dr. McCanse is a na
tive of Washington, D. C., received his preliminar
education at Dartmouth College and his M.D. de
gree at the University of Missouri in 1968. He spe
cializes in urology.

Jack D. Moore, M.D., 4320 Wornall Rd., Kansas ty 64111, has become a member of Jackson unty Medical Society. Dr. Moore is a native of rnesville, Ohio, received his preliminary education at the University of Missouri and his M.D. dee at the University of Missouri in 1970. He ecializes in urology.

bdelmalak E. Morcos, M.D., 2800 Hospital Dr., nsas City 64116, has become a member of Clay unty Medical Society. Dr. Morcos is a native of xor, Egypt, received his preliminary education Ain Shams University and his M.D. degree at Shams University in 1961. He specializes in esthesiology.

---

n Memoriam

Henry J. Ector, M.D., 521 E. Breckenridge, exico 65265, a graduate of Meharry Medical Colle, 1929; member Audrain County Medical Soty; age 88; died Aug. 27, 1975.

min Boutros, M.D., 12011 E. 67th, Kansas City 133, a graduate of St. Louis University, 1914; mber Jackson County Medical Society; age 89; d Aug. 28, 1975.

William W. Wood, M.D., P.O. Box 648, West ins 65775, a graduate of Harvard Medical School, 16; member South Central County Medical Soty; age 52; died Aug. 31, 1975.

Louis E. Freimuth, M.D., 607 N. Grand, St. Louis 03, a graduate of St. Louis University, 1923; mber St. Louis Medical Society; age 89; died pt. 2, 1975.

Elmer A. Lansche, M.D., 8358 Racquet Dr., St. uis 63121, a graduate of the University of Illinois, 23; member St. Louis Medical Society; age 80; d Sept. 4, 1975.

ames P. Wade, M.D., 634 N. Grand Blvd., St. uis 63103, a graduate of St. Louis University, 5; member St. Louis Medical Society; age 77; d Sept. 18, 1975.

Edgar D. Urban, M.D., 215 Tanner, Sikeston 01, a graduate of Vanderbilt University, 1940; mber Semo County Medical Society; age 70; d Sept. 20, 1975.

Hilen K. Wallace, M.D., 8th & Faraon, St. Joseph 01, a graduate of the University of Pennsylvania, 4; member Buchanan County Medical Society; 84; died Sept. 29, 1975.

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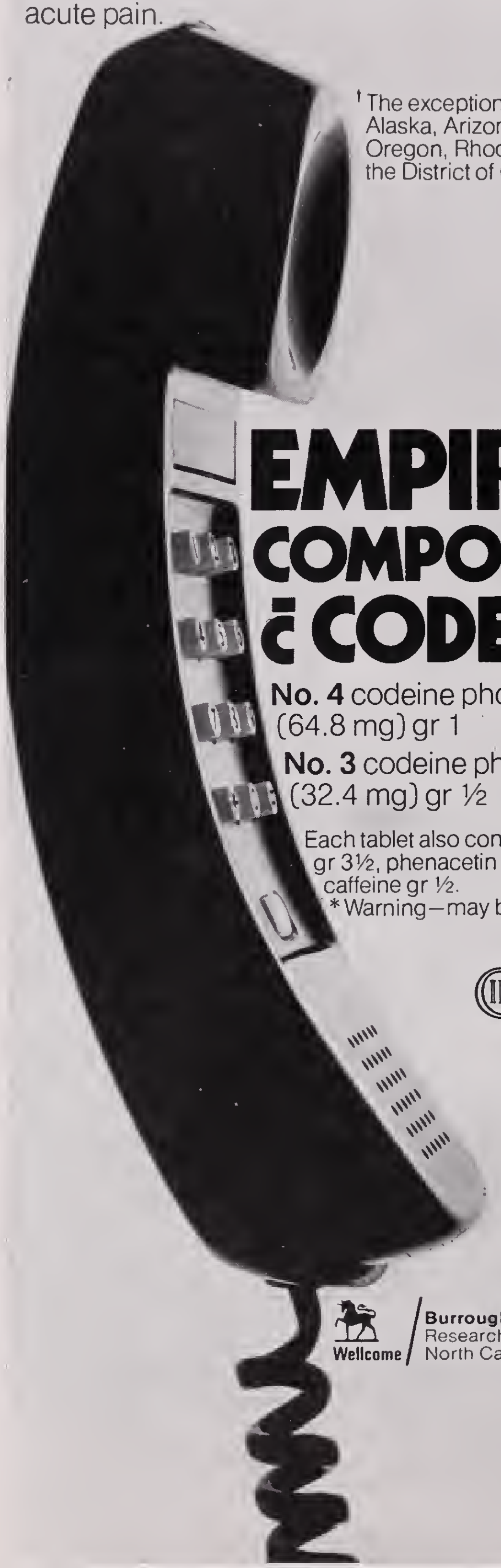

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Council Reports

(Continued from page 636)

should coordinate their efforts in establishing a comprehensive cancer center in the state. These various groups have been meeting and have established a program that is named Missouri Cancer Programs, Inc.

The administrative officers of the seven institutions—University of Missouri Medical Center at Columbia, St. Louis University Medical Center, University of Missouri Medical School at Kansas City, Kirksville College of Osteopathic Medicine, Kansas City School of Osteopathy, Ellis Fischel State Cancer Hospital and the Cancer Research Center—are the incorporators of the Missouri Cancer Programs, Inc. and Bylaws have been drawn up. Dr. John Yarbro has been appointed Director of the program.

Dr. White stated that concern had been expressed that this joint effort had not been reported to the Council and he apologized for not having done so previously. Dr. White stated that Dr. Yarbro, acting as a consultant to the Cancer Research Center, is getting information together and will request a site visit by the National Cancer Institute later this year.

Dr. James Brown, Speaker of the MSMA House of Delegates, thanked the Council for inviting him to the meeting and indicated that he had no report at this time.

REPORT OF THE FIELD SECRETARY

Mr. Don Wilson reported that this Council meeting marked the first anniversary of his field service activities with the Association. The majority of the county medical societies in the state have been contacted more than once and all those contacted have expressed appreciation to the Association for this program. Mr. Wilson stated that during the second year, he hopes to switch from individual contact in a doctor's office to contact at various medical society meetings that he attends within each District and with hospital staffs.

REPORT OF COMMISSION ON MEDICAL ECONOMICS

Dr. Peterson, in the absence of Dr. Chastain, Chairman of the Commission, gave a report on a recent meeting of the Commission. Dr. Peterson stated that Mr. Earl Carlson of General American (Medicare) had attended the meeting. Mr. Carlson informed the members that the Fiscal Year, 1976, prevailing and customary charge data for Medicare is now available through General American. This information will be supplied without charge upon a physician's request. This charge information is itemized into the three geographic areas serviced by General American and listed by specialty and procedure. It indicates the 75th percentile—the actual prevailing charge screen and the 50th percentile that applies to new physicians in their first year of practice in the area. Under the law, the allowed amount for a given service shown on a medical insurance claim is generally the lowest of (1) the actual charge made by the physician for the service; (2) the customary charge generally made for that service by the physician; (3) the *prevailing charge*, which is the charge most physicians in the locality would find acceptable for that service; or (4) the charge that would be recognized by the carrier for its own subscribers or policyholders for the service.

Under the law, just before the beginning of each fiscal year, Medicare reviews the actual charges billed by physicians in the preceding calendar year. The most common of these actual charges by a physician for a service is established as his customary charge for that service. The prevailing charge is then established at the 75th percentile of all individual physicians' customary charges for each service. In effect, the prevailing charge for any given service is amount which is high enough to cover in full the custom charges of those physicians whose billings accounted for least 75% of all claims for that service in the locality in preceding calendar year.

Mr. Carlson then explained the effect of the 17.9% limit reimbursement above the levels prevailing in Fiscal Ye 1971. The AMA has debated this fee index. It has charg that Congress intended local, rather than a national, inc and that the limitation was not supposed to be on a pro dure-by-procedure basis, but on aggregate.

The next item discussed was the work of the Medic Advisory Committee to the Division of Family Services. I Heeb discussed the first draft of the proposed Medicaid schedule as prepared from the existing Medicaid compu program.

Dr. Heeb proposed that certified family physicians considered as specialists by the Medicaid program and entitled to the specialist fee for services performed.

The Commission instructed Drs. Heeb and Peterson meet with state officials and discuss Medicaid problems ar also, to request a reasonable increase in fees to reflect t current economic conditions. They also were requested obtain the percentage of change in Medicaid payments physicians services for the past five years and to reque payment of certified family physicians as specialists.

The next item on the agenda was the discussion of rei bursement to hospitals by St. Louis Blue Cross. Presentl under negotiated contracts, reimbursement is made at t rate of 103% of per diem costs.

On motion, it was recommended that an ad hoc comm tee be appointed by Dr. Chastain to work with represent tives of the Hospital Association and consult with St. Lou Blue Cross. Possibly, Blue Cross could re-negotiate hospit contracts. This committee is also to obtain information the impact of the federal government's cost containme program on hospital reimbursement.

The following resolutions adopted by the MSMA Hou of Delegates in 1975 were referred to this Commission:

Resolution #2—Invasion of Patient Privacy by Goven mental Agencies. It was noted that a PSRO Data Task Forc Steering Committee was studying the problem of confident ality of medical records. The Commission recommends th Dr. Deitchman of St. Louis County prepare a brief repo on "Patient Privacy" and submit it to the Commission. Po sibly, this could be developed and recommended as th MSMA official position on patient privacy and the confide tiality of medical records.

Resolution #15—Development of Individual Practice As sociations. After discussion, the Commission recommend that staff develop an article on Individual Practice Associa tions and print it in Missouri Medicine to inform the mem bership of this alternative to HMO's.

Resolution #26—Third Party Payers. The Commissio accepted this resolution and directed staff to develop a let ter that could be used in replying to Medicare carriers whe this quotation is used in their letter to the beneficiary.

Resolution #27—Patient Education. This resolutio adopts guidelines for third party reimbursement for patien education.

After discussion, the Commission recommends that thi MSMA policy be disseminated in the following manner (1) If the county medical society is staffed, information wil be forwarded through the staff and the society officers t hospital staffs. (2) If the County Medical Society is no staffed, information will be forwarded to the county officer and ascertain from them if the information may be sent directly to hospital medical staffs in their area.

Resolution #30—Uniform Insurance Claim Form. The Commission notes that the objectionable statement con-ned in the Uniform Insurance Claim Form appears to ve been eliminated in the revised claim form that is now ilable.

Resolution #34—Interest Charged on Unpaid Accounts. e Commission accepted for information the report of the IA Judicial Council adopted by the MSMA House of legates concerning the charging of interest on unpaid ac-nts. It is noted that this information is now contained in MSMA Policy Manual.

esolution #38—PL 92-603 (PSRO). The MSMA House Delegates Reference Committee that heard this resolution de the following statement:

> "In reviewing this Resolution, several inaccuracies in eference to sections of Public Law 92-603 were noted. iscussion of Resolution #38 was by proponents of the esolution and certain questions were raised which neither hey nor members of the Committee were able to answer. he Committee feels that members of the MSMA are en-itled to complete and accurate information and discussion f Public Law 92-603. Therefore, the Committee has the ollowing recommendation:
>
> "The Reference Committee recommends that Resolu-ion #38 be referred to the Commission on Medical Eco-omics and Third Party Medicine for further study and larification and that that Commission's report be dissemi-ated to the members of the MSMA."

t was the consensus of those present that they did not y understand the resolution. It is recommended that the Jackson County members of the Commission, Drs. Grif- and Braverman, discuss this with the writer of the reso-on. Perhaps, he would like to present clarifying informa- and, possibly, present testimony at the next Commission eting.

r. Esther discussed a letter and statement on the billing n provided the insured and the physician by an insur-e company that provides coverage for a large factory in area. Many physicians in the Jasper County area provide ices for these employees. This statement to patients vides:

If the above benefits paid for surgery, surgical assistance, /or anesthesiology do not pay the doctor's charges in , a dispute exists regarding the fees charged and the rea-able and customary fee as indicated by BFG Surgical sultants. Your doctor has been notified of this. If you e not made a previous agreement with him regarding amount of his fee and you decide not to pay this differ-e, any attempt by the doctor to collect any remaining nce through legal proceedings should be reported ugh personnel immediately for assistance."

he letter to the physician outlines that benefits are based reasonable and customary fees for the services rendered that a physician has the right to charge whatever unt he feels proper, but the benefit payable does not al the fee charged and it gives the upper limits of the ge of fees for the procedure performed. The Jasper nty Medical Society will discuss this at its next meeting.

he Commission recommends to the Council that immedi- action be taken to inform the insurance company that statement to the patients of cost is unethical and that it ld be discontinued. It further recommends that MSMA pt a policy statement against this type of letter.

r. Hetlage stated that this is a serious matter and, in ct, what the insurance companies were doing was to sell CR policy without going to doctors and getting them ed up to accept UCR and then tried to force UCR on -voluntary physicians. Dr. Hetlage indicated that he had pared a resolution on this which is as follows:

> HEREAS, UCR programs, by their very nature require the signed cipation by a physician to bind him to a UCR fee schedule, and
>
> WHEREAS, The recent experience with practicing physicians throughout the State with two major insurance companies would seem to indicate a move to force UCR schedules upon non-participating physicians, therefore be it
>
> *Resolved*, That the Council of the Missouri State Medical Association makes hereby known that the profession of medicine in Missouri condemns this type of action as intolerable and will take any action necessary, including legal intervention, to preserve the right of the practicing physician to set his fee as an independent transaction between him and his patient, free of third party intrusion, except in those instances where the physician has voluntarily agreed to accept a UCR schedule by signed consent.

Dr. Hetlage moved the adoption of the above resolution. Motion was seconded and carried.

During discussion on this matter, it was suggested that, perhaps, a letter should be written to the insurance companies informing them of the above resolution.

Motion was made, seconded and carried for adoption of the entire report.

DATA TASK FORCE REPORT

Dr. McCanse, MSMA representative to PSRO Data Task Force and Missouri Center for Health Statistics Task Force, stated that the Council on May 31 had approved in principle the proposal from the five PSRO groups that a central collecting agency for hospital discharge data information be developed. Confidentiality would be assured by a board of directors of such corporation made up of providers, including physicians and hospital association members and various data users. Since the May Council meeting, articles of incorporation and bylaws for the new corporation have been proposed and funding sources looked into.

The Division of Health currently has a hospital discharge data program and Missouri PSRO officials were informed that the national PSRO officials would not fund a new data processing system if there were an existing system in operation which could provide the necessary information. It has been proposed that the concept of the corporation be changed from a data collection and processing corporation to an advisory corporation to the Division of Health where matters concerning confidentiality and release of information could be addressed and resolved.

Dr. McCanse reported that Dr. McAlhany had received a letter from Dr. Frank Maple, Chairman of the Data Steering Committee, asking that the MSMA submit names of five members for the board of directors of the corporation.

Dr. McCanse stated that he would like to submit the following recommendations for consideration by the Council:

1. Because of the change in the purpose of the corporation from operational to advisory, it is questionable that the MSMA should participate in the sponsored corporation at this time. The corporation is not in keeping with the original concept of having a private collection and processing agency as approved by the MSMA.
2. An up-to-date report from the PSRO groups on what direction they feel should be taken is necessary in order for MSMA to consider the various alternatives.
3. MSMA should consider advantages and disadvantages of having the Division of Health collect these data in order to satisfy the needs of the various data users and the advantages and disadvantages of serving in an advisory corporation to the Division of Health.

Dr. Domke stated that at this point, more facts would have to be known about the situation in order to do more planning. He indicated that we are far short of having a final system. Dr. Domke stated that under some of the new legislation coming out of Congress, there would be lots of people who would have legitimate interests in information of this type and, if possible, a single system would be desirable in which providers and users would participate and exercise the appropriate degree of control.

On motion, duly seconded, the report on the Data Task

Force by Dr. McCanse was accepted as information only. Motion carried.

REMARKS OF THE PRESIDENT

Dr. Chandler stated that last year, President Cope had appointed Dr. Clement Grebel of St. Louis as MSMA representative to the PSRO Support Center. Dr. Chandler stated that he felt that Dr. Grebel should be reappointed as he is very knowledgeable and hardworking in this area. Motion was made, seconded and carried to reappoint Dr. Grebel.

Dr. Chandler stated that the Governor's Task Force on Malpractice is in operation and Dr. McAlhany is doing an excellent job on this Task Force. He indicated that he agrees that we should support the four bills that will come out of the Senate Select Committee.

President Chandler stated that he had been receiving letters from physicians expressing concern over MSMI and the MSMA's failure to set up a mutual insurance company. He indicated that he had received an invitation from the Kansas Medical Society for our malpractice committee to meet with theirs to compare ideas and goals.

NEXT COUNCIL MEETING

The December Meeting of the Council will be held on December 12 and 13, 1975, at the Holiday Inn in Jefferson City. There will be a meeting of the Finance and Budget Committee at 1:30 PM on December 12.

EXECUTIVE SESSION

Dr. McAlhany adjourned the regular Council Meeting and called for an Executive Session. The following matters v discussed and actions taken:

Mr. McIntyre explained briefly that MSMA Legal Co sel felt the MSMA should change its trustees on the F sion Program from the three individual trustees to a porate trustee because of the liability under the new fed pension law. At a previous Council Meeting, the Council proved the working out of the details establishing Merc tile Trust Company as the corporate trustee for the Pens Program. These details have been worked out and proper papers drawn up for the transfer from the pres three individual trustees to a corporate trustee, Mercan Trust Company. Mr. McIntyre requested that the Cou give the MSMA President authority to sign the papers m ing this transfer and releasing the present three trustees the MSMA Employees' Pension Program from all respo bility and liability as trustees of the Pension Program.

On motion, duly seconded, such authority was gran and the proper papers signed by Dr. Chandler, President MSMA.

Dr. Hetlage brought up the subject of HSAs and the satisfaction of some of the physicians in his particular a After brief discussion, motion was made that the Council the MSMA inform the Governor of the dissatisfaction of doctors in HSA District II and to request that he reemp size his personal concern regarding the lack of wisdom this total legislative effort. However, by assuming a coope tive posture that we request Area II be changed in suc manner that the five areas of the State will then corresp to the existing PSRO boundaries. The motion was secon and carried.

★

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LEO H. POLLOCK, M.D.

issouri Medicine in Review

ORTY YEARS AGO

There are few groups or individuals who did t lament keenly the death of Dr. Walter Wil- ms on July 29 in Columbia. While Dean illiams was before all things a journalist, his in- ence was felt in all fields and probably some- at more in the medical profession than in many er fields.

Dr. Williams began as a printer's devil and be- ne probably the best known Missouri citizen oughout the world. He founded and become an of the University of Missouri School of rnalism in 1908. It was the first such school in world and a model for many others through- the world. In 1930, he was drafted for the sidency of the University and conducted the iversity through the worst economic storm of history.

mong his achievements as president was the ption of the five-year course in the School of w and the reinstatement of the four-year cur- ulum in the School of Medicine, both of which re temporarily suspended so that the University ld accommodate the students already enrolled.

ean Williams placed medical men on the pro- m of Journalism Week and appointed them to advisory council of the University. Physicians re numerous among his friends and counselors.

VENTY-FIVE YEARS AGO

alph R. Coffey, M.D., Kansas City, participated a two-week Child Guidance course and taught “ealth Problems” at Purdue University in July.

The outlook for graduation of more physicians better than it has ever been. The total enroll- nt in the 72 medical schools and seven basic science schools was 25,103 for the academic year, 1949-1950. This represents an increase of 1,333 students or 6% over the preceding year. The latest total is double the enrollment in 1910 (12,530) and about 18% higher than that of ten years ago. It also is larger than during the years of World War II when extra classes were enrolled in all medical schools on an accelerated program.

The Rev. Alphonse M. Schwitalla, S.J., dean emeritus of the St. Louis University School of Medicine, celebrated his 50th year in the Society of Jesus on July 25. A high mass was offered in St. Francis Xavier Church.

Buford G. Hamilton, M.D., who is better known to Missouri physicians as Dr. Buford, has been director of the State Division of Health for the last six months. For many years, he practiced in his chosen field of obstetrics and gynecology in Kansas City. Dr. Hamilton has taught many Kansas City and outstate physicians at the General Hospital and St. Luke's Hospital in Kansas City.

TEN YEARS AGO

Dr. Carl A. Moyer, head of the Department of Surgery and Bixby Professor of Surgery at the Washington University School of Medicine in St. Louis, has resigned. The 57-year-old physician headed the Department of Surgery for the past 14 years. He is nationally known in his field and won new recognition early this year when he and Dr. William W. Monafo reported their work with a new silver nitrate treatment for severe burn cases. He is a native of Michigan and a graduate of the University of Michigan School of Medicine. He reportedly is considering an affiliation with a small college in that state.

Dr. Henry G. Schwartz, professor of neurological surgery, has been named acting head of the Department of Surgery to succeed Dr. Moyer.

The Grand River Medical Society and Auxiliary held their first 1965 fall meeting at the Strand Hotel in Chillicothe on September 9. Thirty-eight members and guests attended. After the social hour and dinner, Dr. Maxwell Berry, a Kansas City internist, discussed “The Modern Management of Cardiac Arrhythmias.”

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ications: Relief of anxiety and tension curring alone or accompanying various ease states.
ntraindications: Patients with known persensitivity to the drug.
rnings: Caution patients about possible nbined effects with alcohol and other S depressants. As with all CNS-acting gs, caution patients against hazardous cupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation or in women of child-bearing age requires that its potential benefits be weighed against its possible hazards.
Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.
Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.
Usual Daily Dosage: Individualize for maximum beneficial effects. *Oral—Adults:* Mild and moderate anxiety and tension, 5 or 10 mg *t.i.d.* or *q.i.d.*; severe states, 20 or 25 mg *t.i.d.* or *q.i.d. Geriatric patients:* 5 mg *b.i.d.* to *q.i.d.* (See Precautions.)
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ease see following page.

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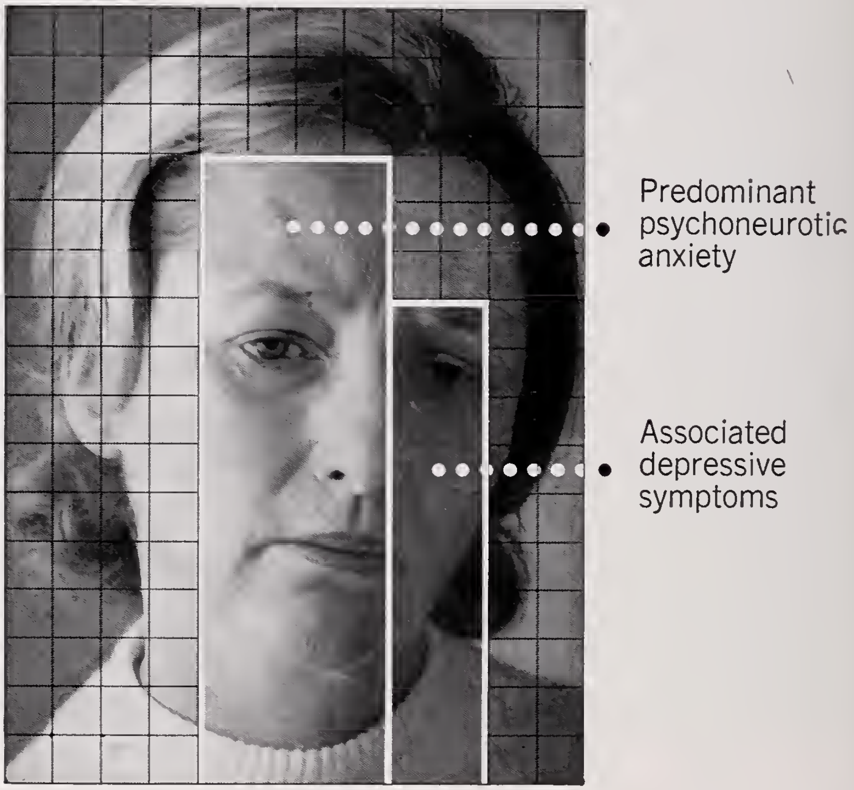
SPECIAL ISSUE**

Both ofte


Predominant psychoneurotic anxiety
Associated depressive symptoms

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in fr and/or severity of grand mal seiz require increased dosage of stand convulsant medication; abrupt wi may be associated with temporar crease in frequency and/or severi seizures. Advise against simultan gestion of alcohol and other CNS sants. Withdrawal symptoms (sim those with barbiturates and alcoh occurred following abrupt discont (convulsions, tremor, abdominal cle cramps, vomiting and sweatin addiction-prone individuals under

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tient with severe
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nd like depression.
ecause her problem,
h primarily one of ex-
anxiety, is often accom-
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Valium (diazepam)
vide relief for both—as
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re are other advan-
using Valium for the
ment of psychoneu-
xiety with secondary
ve symptoms: the
herapeutic effect of
is pronounced and
his means that im-
ent is usually apparent in the patient within a few days rather than in a week or two, although it may take longer in some patients. In addition, Valium (diazepam) is generally well tolerated; as with most CNS-acting agents, caution patients against hazardous occupations requiring complete mental alertness.

Also, because the psychoneurotic patient's symptoms are often intensified at bedtime, Valium can offer an additional benefit. An *h.s.* dose added to the *b.i.d.* or *t.i.d.* treatment regimen can relieve the excessive anxiety and associated depressive symptoms and thus encourage a more restful night's sleep.

Valium® (diazepam) Ⓘⓥ

2-mg, 5-mg, 10-mg scored tablets

in psychoneurotic
anxiety states
with associated
depressive symptoms

ce because of their predisposi-
bituation and dependence. In
y, lactation or women of child-
ge, weigh potential benefit
ossible hazard.
ns: If combined with other psy-
s or anticonvulsants, consider
harmacology of agents em-
ugs such as phenothiazines,
barbiturates, MAO inhibitors
antidepressants may potentiate
Usual precautions indicated in
everely depressed, or with latent
n, or with suicidal tendencies.

Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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Missouri Medicine

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MSMA NEWS

ROUND - UP

DECEMBER, 1975

AMA President to address MSMA Convention

Max H. Parrott, M.D., President of the American
edical Association, will be one of the featured
eakers at the Opening General Session of the
SMA's Annual Session, April 1-4, 1976, at the Crown
nter Hotel in Kansas City.

Dr. Parrott, a practicing obstetrician-gynecologist
om Portland, Ore., announced plans to attend the en-
re MSMA Convention and will participate in several
her activities. He will give a short talk at the Opening
ssion of the House of Delegates, Thursday, April 1,
d will address the Woman's Auxiliary-MMPAC
eakfast on Saturday morning, April 3.

U.S. Representative Paul Rogers, Chairman of the in-
ential Subcommittee on Health and Environment of
e House Interstate and Foreign Commerce Committee,
s tentatively announced plans to join Dr. Parrott on
e program of the Opening General Session, at 9 a.m.,
iday, April 2. Rep. Rogers, of Florida, is the sponsor of
veral important health and medical related bills.

Dr. Parrott has expressed great concern about the
rust and proliferation of recent federal and state
alth legislative proposals that tend to make the deliv-
y of medical care more rigid, less personal and in-
easingly subject to regulatory controls.

"Individual responsibility for managing patient care is
tal," Dr. Parrott emphasizes. "The personal doctor pa-
nt-relationship is central to good medical care. I think
e physician can survive without it. But I'm not so sure
e patient can."

Dr. Parrott was a member of the AMA's policy-mak-
g House of Delegates from 1961-1966. He was a mem-
r of the AMA's Council on Legislation from
61-1965.

Dr. Max H. Parrott .... AMA President

Members request pamphlets

Several MSMA members have requested additional copies of the pamphlet, "The Missouri Malpractice Situation — A Crisis?", to be placed in their waiting rooms.

Ten copies of the pamphlet were mailed to each MSMA member. The pamphlet is designed to explain the malpractice crisis to the general public.

Additional copies of the pamphlet can be obtained by writing to MSMA Headquarters, P.O. Box 1028, Jefferson City, Missouri 65101.

Cole heads EMS Bureau

Kenneth E. Cole, Jr., took office recently as director of the state Bureau of Emergency Medical Services, announced Dr. Herbert R. Domke, director of the Missouri Division of Health. Cole succeeds Dr. John K. Wallace, II, who retired July 1 after eight years directing statewide EMS programs.

Cole, 32, previously was director of the Office of Emergency Medical Services in the Wyoming Division of Health and Medical Services at Cheyenne. He helped establish the Wyoming state EMS agency in 1971 and had been its only director until his resignation to accept the EMS position in Missouri.

Missouri physicians receive recognition awar

A total of 199 Missouri physicians were recently listed as recipients of the 1974 AMA Physician's Recognition Award.

The Award is a voluntary continuing medical education (CME) program designed to improve physician competence and recognize physicians active in CME. In 1974, 16,919 physicians qualified for the Award nationally.

To qualify for the Award, each physician had to complete 150 credit hours of CME in three years. Sixty of the credit hours must be earned in Category 1 programs.

Those receiving the 1974 Physician's Recognition Award are:

Outstate

Drs. Arturo H. Montellano, *Monett*; Onssy H. Anis, Curtis H. Bourgeois, William R. Bynum, George A. Craft, Mujtaba Husain, Robert J. King, Carroll R. Markivee, Michael D. Milroy, Larry D. Mosby, Walid O. Shekim, and George P. Wilson, *Columbia*.

Drs. Robert C. Engelhardt, Abbiah N. Reddy, Sarvotham K. Reddy, Delbert E. Tiffany, William L. Traxel, and Barry B. White, *Poplar Bluff*; Soo-Ja Lee, *Fulton*; Kenneth D. Ridgeway, *Macks Creek*; Ernest D. Johnson and Paul A. Spence, *Cape Girardeau*; Royal S. Garner, *Jefferson City*; J. Larry Dowell, *Pattonsburg*; Dorwyn W. Croom, *Malden*; Carl E. Aulenbacher, *Washington*; and George A. Richardson, *Union*.

Drs. Paul T. Berry, Frederick C. Coller, Francis M. Corry, Boonmee Enkvetchakul, George E. Farley, Walter J. Gaska, Sally L. Hubbard, Leo T. Neu, V. Padmanabha-Rao, Guido I. Podrecca, and Robert B. Stewart, *Springfield*; and William D. Bradshaw, *Clinton*.

Drs. Frank I. Clark, Ira J. Pryor, and David L. Straub, *Joplin*; Richard R. Cohle and Gil B. Manalo, *Carthage*; Oblendo A. Cuento, *High Ridge*; Manoch Kuangparichat, *Lexington*; Earl L. Rapp, *Hannibal*; Ambrose T. Walker, *Thayer*; Sanan Saengsamran, *Hayti*; and Alfred E. McDermott, *Perryville*.

Drs. Won-Jong Sull, *Sedalia*; H. N. Grannemann, *Rolla*; Earl A. Neal, *Fort Leonard Wood*; Emilio B. Apostol, *O'Fallon*; Charles M. Linsenmeyer and Mohammad H. Rahman, *St. Charles*; Grinny H. C. Ho and Edwin J. Masters, *Sikeston*.

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CME material coming soon!!

MSMA members soon will be receiving a explanation of the Association's new *voluntary* Continuing Medical Education (CME program. Also, each member will receive a file folder upon which he can convenientl record his CME activities.

Instructions on how the CME progra works were published in the September an November issues of MISSOURI MEDICINE In addition, communications have been submitted to the county society BULLETIN and to the Presidents and Secretaries o local societies.

If you or your society desires further explanation of the program, MSMA Headquarters will furnish additional information o arrange for someone knowledgable on th subject to address your society.

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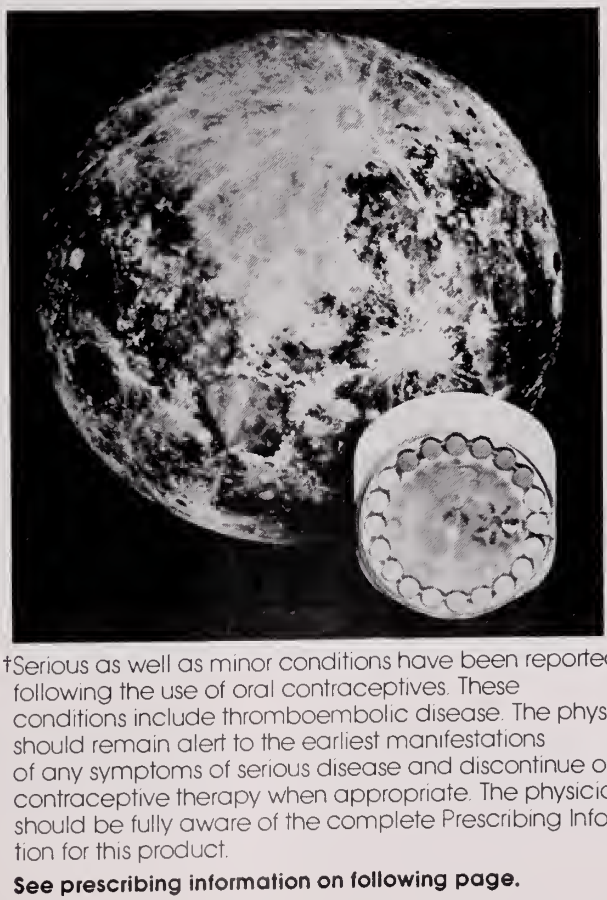

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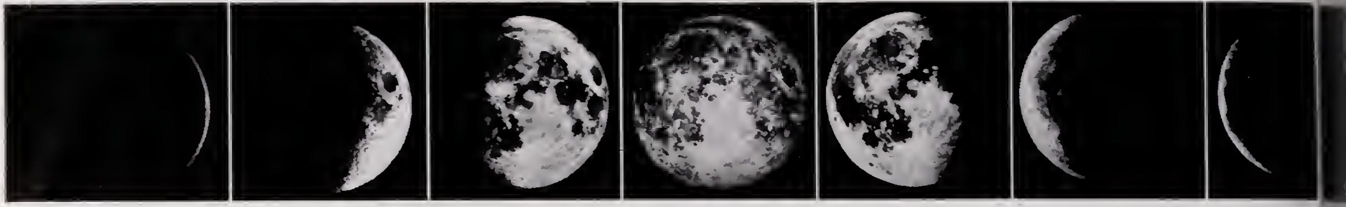

Ortho-Novum SQ Tablets

TRADEMARK

Description: ORTHO-NOVUM SO Tablets provide a sequential oral contraceptive regimen consisting of white tablets containing only mestranol 0 08 mg, and blue tablets containing both mestranol 0 08 mg and norethindrone 2 0 mg

Action: Gonadotrophin suppression.

Special note: Oral contraceptives have been marketed in the United States since 1960. Reported pregnancy rates vary from product to product. The effectiveness of the sequential products appears to be somewhat lower than that of the combination products Both types provide almost completely effective contraception

An increased risk of thromboembolic disease associated with the use of hormonal contraceptives has now been shown in studies conducted in both Great Britain and the United States. Other risks, such as those of elevated blood pressure and reduced tolerance to carbohydrates, have been reported and appropriate tests should be conducted to monitor these during oral contraceptive therapy Liver disease has also been reported, and the physician should be alert to its earliest manifestations

Long-term administration of both natural and synthetic estrogens in subprimate animal species in multiples of the human dose increases the frequency for some animal carcinomas These data cannot be transposed directly to man The possible carcinogenicity due to the estrogens can neither be affirmed nor refuted at this time Close clinical surveillance of all women taking oral contraceptives must be continued

Indication: Contraception

Contraindications: 1 Thrombophlebitis, thromboembolic disorders, cerebral vascular disease, or a past history of these conditions 2 Markedly impaired liver function 3 Known or suspected carcinoma of the breast 4 Known or suspected estrogen-dependent neoplasia 5. Undiagnosed abnormal genital bleeding 6 Known or suspected pregnancy

Warnings: 1 The physician should be alert to the earliest manifestations of thrombotic and thromboembolic disorders, thrombophlebitis, cerebrovascular disorders including hemorrhage, pulmonary embolism and retinal thrombosis Should any of these occur or be suspected, the drug should be discontinued immediately

Retrospective studies of morbidity and mortality in Great Britain and studies of morbidity in the United States have shown a statistically significant association between thrombophlebitis, pulmonary embolism and cerebral vascular disease, occlusive or hemorrhagic, and the use of oral contraceptives There have been three principal studies in Great Britain[1-3] leading to these conclusions and three in this country [4-7] The estimate of the relative risk of thromboembolism in the study by Vessey and Doll[3] was about sevenfold, while the United States studies found relative risks of 4 4 to 11, meaning that the users are several times as likely to undergo thromboembolic disease without evident cause as non-users

In May, 1974, the Royal College of General Practitioners in England[8] issued an interim report of its continuing large-scale prospective study comparing a user group to a non-user group This study in its interim analysis states. A statistically significant higher rate of reporting of cerebrovascular accidents in Takers is evident, but the numbers are too small to justify an estimation of the degree of risk The study also reported a higher incidence of superficial and deep vein thrombosis in users as compared to non-users The risk of superficial and deep vein thrombosis was reported to be lower in women using 50 mcg estrogen preparations

The Sartwell study[4] indicated that the risk did not persist after discontinuation of administration. Both the Sartwell and the Royal College studies indicated that the degree of risk was not associated with duration of treatment

In a collaborative American study[5,6] of cerebrovascular disorders in women with and without predisposing causes, it was estimated that the relative risk of thrombotic stroke was 4 1 to 9 5 times greater in users than in non-users A comparable estimate for hemorrhagic stroke was 2.0.

None of the American studies was designed to evaluate a difference between products However, the Sartwell study[4] suggested that there might be an increased risk of thromboembolic disease in users of sequential products

Other retrospective studies[9,10] have reported an increased risk of post-surgery thromboembolic complications in oral contraceptive users It has been recommended that therapy be discontinued at least one month prior to elective surgery

2 Discontinue oral contraceptive medication if there is: gradual or sudden partial or complete loss of vision; proptosis or diplopia, onset or aggravation of migraine or development of headache of a new pattern which is recurrent, persistent or severe; papilledema, or any evidence of retinal vascular lesions

3. Fetal abnormalities have been reported to occur in the offspring of women who have taken progestogens and/or estrogens during pregnancy [11,12] The safety of ORTHO-NOVUM SO in pregnancy has not been demonstrated Pregnancy should be ruled out before initiating or continuing the contraceptive regimen. Pregnancy should always be considered if withdrawal bleeding does not occur

4 A small fraction of the hormonal agents in oral contraceptives has been identified in the milk of mothers receiving these drugs. The long-range effect to the nursing infant cannot be determined at this time

5 Hepatic lesions (adenomas, hepatomas, hamartomas, regenerating nodules, etc), occasionally fatal, have been reported in women on oral contraceptives. Such lesions may present as an abdominal mass or with the signs and symptoms of an acute abdomen. These lesions should be considered if the patient has abdominal pain or evidence of intra-abdominal bleeding. This has been reported in short-term as well as long-term users of oral contraceptives.

Precautions: 1. A thorough history and physical examination should be performed bef
ing oral contraceptives and periodically during their administration and should include s
ence to breasts and pelvic organs, including Papanicolaou smear since estrogens have l
to produce tumors, some of them malignant, in five species of subprimate animals 2 En
possibly liver function tests may be affected by treatment with ORTHO-NOVUM SQ 1
such tests are abnormal in a patient taking ORTHO-NOVUM SO, it is recommended t
repeated after the drug has been withdrawn for two months. 3. Under the influence
progestogen preparations, pre-existing uterine fibromyomata may increase in size. 4 Bec
agents may cause some degree of fluid retention, conditions which might be influenced b
such as epilepsy, migraine, asthma, cardiac or renal dysfunction, require careful obser
breakthrough bleeding, and in all cases of irregular bleeding per vaginam, nonfunctic
should be borne in mind. In undiagnosed bleeding per vaginam, adequate diagnostic me
indicated. 6. Patients with a history of psychic depression should be carefully observed a
discontinued if the depression recurs to a serious degree. 7. Any possible influence of
ORTHO-NOVUM SO therapy on pituitary, ovarian, adrenal, hepatic or uterine function aw
study 8 A decrease in glucose tolerance has been observed in a significant percentage
on oral contraceptives The mechanism of this decrease is obscure. For this reason, diabe
should be carefully observed while receiving ORTHO-NOVUM SO therapy. 9. The age of
constitutes no absolute limiting factor, although treatment with ORTHO-NOVUM SQ ma
onset of the climacteric 10 The pathologist should be advised of ORTHO-NOVUM SQ the
relevant specimens are submitted. 11 Susceptible women may experience an increas
pressure following administration of contraceptive steroids 12. Cholestatic jaundice
reported in users of oral contraceptives. If this occurs, ORTHO-NOVUM SO should be dis
This condition is more likely to occur in patients who have experienced cholestatic jaund
nancy Patients with a history of cholestatic jaundice of pregnancy should be carefully ob
ing ORTHO-NOVUM SO therapy

Adverse reactions observed in patients receiving oral contraceptives: A statistically
association has been demonstrated between use of oral contraceptives and the follow
adverse reactions. thrombophlebitis, pulmonary embolism, cerebral thrombosis and he
gallbladder disease

Although available evidence is suggestive of an association, such a relationship has be
confirmed nor refuted for the following serious adverse reactions. neuro-ocular lesions, e
thrombosis and optic neuritis; hepatic lesions with or without intra-abdominal bleeding

The following adverse reactions are known to occur in patients receiving oral contr
nausea, vomiting, gastrointestinal symptoms (such as abdominal cramps and
breakthrough bleeding, spotting, change in menstrual flow, amenorrhea during and after
edema, chloasma or melasma, which may persist, cholestatic jaundice, migraine, rash
mental depression, change in weight (increase or decrease), breast changes (tendernes
ment and secretion), changes in cervical erosion and cervical secretions, suppression c
when given immediately post-partum, rise in blood pressure in susceptible individuals

Although the following adverse reactions have been reported in users of oral contrace
association has been neither confirmed nor refuted anovulation post-treatment, which tend
more frequently in women with a history of menstrual disorders; premenstrual-like s
changes in libido; changes in appetite, cystitis-like syndrome; headache; intolerance to c
ses, nervousness; dizziness; fatigue; backache; hirsutism; loss of scalp hair; erythema m
erythema nodosum, hemorrhagic eruptions; itching, vaginitis.

The following laboratory results may be altered by the use of oral contraceptives. hepatic
increased sulfobromophthalein retention and other tests; coagulation tests—increase in pr
Factors VII, VIII, IX and X, decrease in anti-thrombin III; increase in platelet aggregabilit
function—increase in PBI, and butanol-extractable protein-bound iodine and decrease in
values; metyrapone test, pregnanediol determination.

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WASHINGTON

The continual improvement in our health system, h its ever-increasing responsiveness to the peo- 's needs, must not be stifled by adopting foreign- vored elements into a national health insurance n, the American Medical Association has told Congress.

When considering a national plan for this coun- , it is necessary to take cognizance of the ngths of our own method of health care de- ry . . . this will assure that our excellent sys- will continue to improve and will not suffer the ling effects experienced in other countries," AMA sident Max H. Parrott, M.D. testified before a committee of the House Ways and Means Com- tee.

Pointing to the large problems involved in cre- g a national health insurance program, Dr. Par- , a Portland, Ore. practitioner, said that the pub- attitudes toward it are changing steadily:

These problems have been brought into better us as a result of evidence of the effects of gov- mentally administered and controlled programs h here and abroad.

Our national priorities have also shifted because the effects of the changing economy and the astating effects of inflation on all segments of society.

The public has expressed among its major prior- s a concern with inflation, with the state of the nomy and with crime. National polls have in- ated that national health insurance is of low con- n.

During this same period of time, significant nges have taken place in our health system ough increased manpower programs, increased lities construction, increased levels of private lth insurance coverage and a variety of other grams. There is fuller realization and acknowl- ement that this country's health system—under ck by many in the course of the NHI debate— ndeed, superior to any other in the world," Dr. rott said.

r. Parrott and Richard E. Palmer, M.D., of xandria, Va., and Chairman of the AMA Board Trustees, reminded the subcommittee members the medical profession's national health insur- e plan (H.R. 6222) which builds on the struc- of the present system of employer-employee group health insurance plans, mandating each employer to provide comprehensive and catastrophic benefit coverage with the employer picking up at least 65% of the cost.

Dr. Palmer pointed out that in pressing for the adoption of any particular NHI proposal, sincerity must not be confused with objectivity—"We cannot afford to have a program of such importance fail!

"We must avoid the mistake inherent in proposals such as H.R. 21 (Kennedy-Corman) which would lock medicine into a rigid, monolithic, no-choice bureaucratic system. Such a creation would be impossible to reverse. It would be an undertaking full of promise but empty of fulfillment. Establishment of cost control through fixed budgets including arbitrary fee schedules would result in curtailment of care and discourage participation by providers. A look at the current trouble of the British health care system impels a close reexamination of the alleged need for such drastic action, as is embodied in H.R. 21. In our opinion justification for such a program is totally lacking!"

Alluding to other measures aimed at providing catastrophic health insurance alone, Dr. Palmer observed that 135 million Americans under the age of 65 carried major medical insurance in 1974.

"This is the most rapidly growing form of health insurance in the nation, and the trend for such added coverage is fostered by an increasing public awareness. Consequently, we must question the need to impose on the American taxpayer and consumer a costly universal federal program of free-standing catastrophic insurance."

The National Health Insurance hearings on Capitol Hill have been marked so far by a notable lack of excitement or sense of urgency. The national news media has ignored the first legislative hearings of the year on NHI, underscoring contentions by many witnesses that the public doesn't rate NHI high on its scale of worries or interests.

Nonetheless, the recently announced decision that the House Interstate and Foreign Commerce Committee's Subcommittee on Health will conduct NHI hearings brings into the open anew the odd jurisdictional dilemma that perplexes Congress in its quest for action on NHI. Rep. Paul Rogers (D-Fla.) has announced that his House Commerce

(Continued on page 720)

JIM T. LACY *and* **JOHN S. SPRATT, JR., M.D.,** ***Colum***

Expansion Program Increases Services For Patients at Ellis Fischel State Cancer Hospital

Special Feature

A HOSPITAL considered as outstanding when it opened[1] has maintained that status through more than 35 years of service to Missouri cancer patients by looking beyond the todays to the tomorrows.

In June, 1974, Ellis Fischel State Cancer Hospital in Columbia began an expansion and renovation project that is now about 75% completed. A new addition will more than double existing space in the 113-bed specialty hospital operated by the Division of Health, Missouri Department of Social Services. Facilities for the outpatient clinic, clinical laboratories and diagnostic radiology will be greatly modernized. The cost is almost $10 million. The Missouri General Assembly appropriated $7.6 million for the expansion in 1973, and the Division of Health, through its Program Improvement Fund, provided almost $2 million more for an addition to and equipment for the Radiation Therapy Department in 1974 and 1975.

The uniqueness of Ellis Fischel Hospital and the purpose behind its founding placed a special obligation for the professional, administrative and support staffs to follow in providing diagnosis, treatment and rehabilitation for the 44,523[2] Missourians with cancer who have received inhospital or outpatient care since April, 1940.

Ellis Fischel is the second state-operated hospital established solely for the treatment of cancer in the United States[3] and the first west of the Mississippi River. Originally, it was to provide care and tr ment of cancer for those Missourians who co not pay. Now, all Missourians with known or r sonable suspicion of cancer are eligible for di nosis and treatment upon referral by a physician dentist.

Phase I of a multi-phase expansion program at Ellis Fischel State Cancer Hospital is scheduled for completion by fall, 1976. It includes the first major addition to the 35-year-old Cancer Hospital since it opened in April, 1940 and an 8,500 sq ft addition to the Radiation Therapy Department.

Mr. Lacy is Director of Community Relations and Dr. Spratt is Director of the Cancer Research Center and Chief Surgeon at the Cancer Hospital. This investigation was supported by Clinical Cancer Training Grant CA-08018 from the National Cancer Institute.

Major elements of the current Phase I of a mu phase expansion program are a three-story a basement wing (Figs. 1 & 2), renovation of f floors of the present seven-story hospital build and an 8,500 sq ft addition to the Radiation Th apy Department (Fig. 1). Several departments be transferred from the present building to new wing. Partial or complete renovation of so floors in the old building will enlarge some depa ment areas and allow for new services. Some p tions of the work will be completed early in 19 with full occupancy expected by early fall, 1976

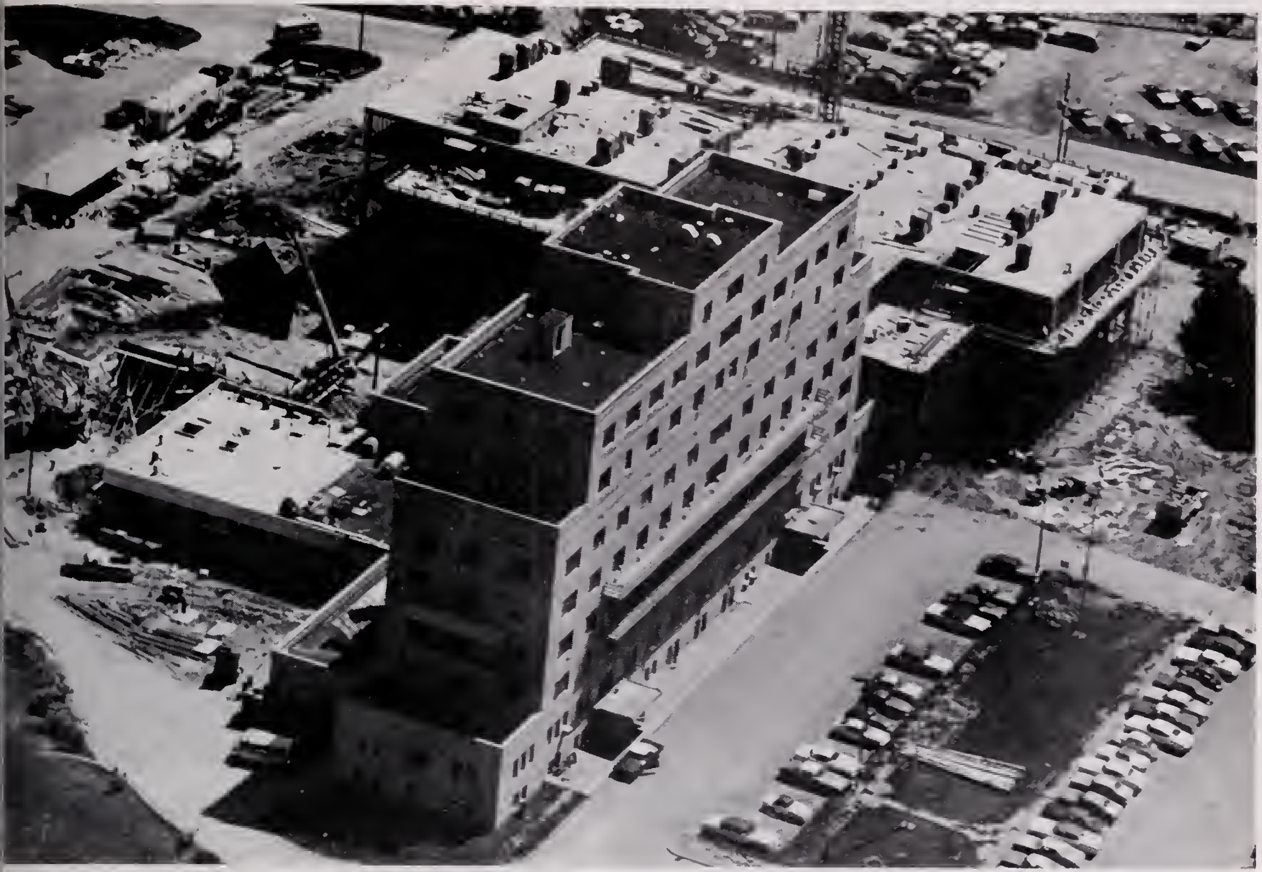
New equipment in the Radiation Therapy I partment will include a 40 MeV linear accelera (Sagittaire) and a patient treatment simula (Therasim 750). This equipment represents an vestment of more than $1.25 million and will ready for patient use by March, 1976.

The General Assembly has yet to approve fun for Phases II and III.

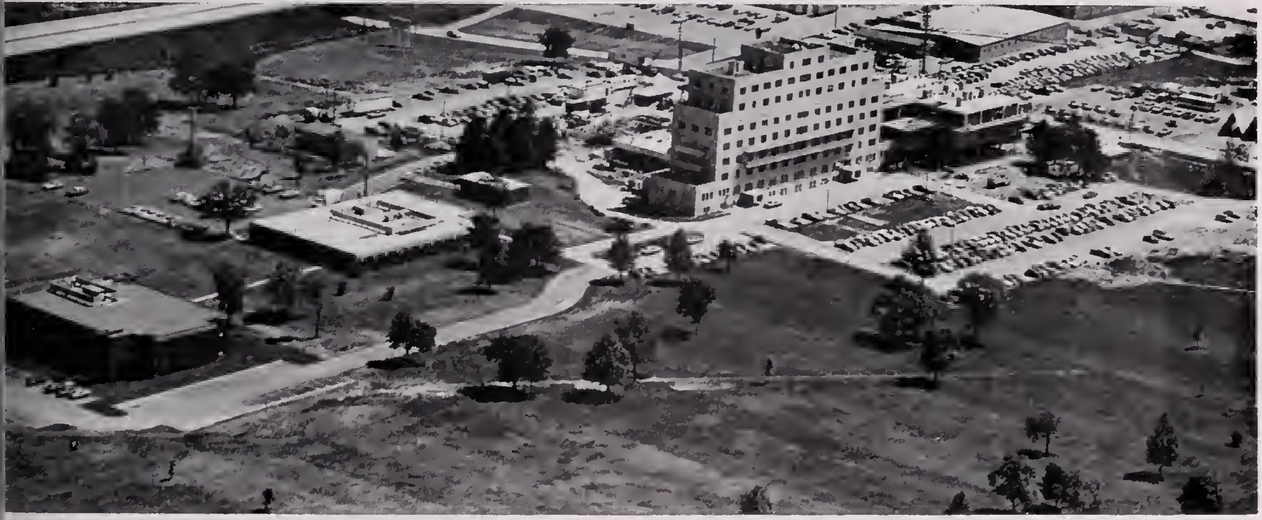
Phase II expansion tentatively would include two-floor addition to the new wing. The fourth flo only would be finished during this phase to provi an additional 63 patient beds. During this pha the first floor of the present building would renovated to provide more space for administrati operations.

Phase III calls for renovation of the second, thi and fourth floors of the present building and parti renovation of the fifth floor. During this propos last phase, the fifth floor of the new wing would finished to provide 63 additional patient beds.

The additions and modernization of services a facilities at Ellis Fischel State Cancer Hospital a designed to bring the entire medical communi together with the public by helping cancer patien to face their problems and to reach satisfacto solutions. By providing service, education and r habilitation and through research conducted by t



ig. 1 Ellis Fischel State Cancer Hospital in June, 1975, one year after construction of a new wing began. The three-y and basement wing addition *(top)* and the boiler room addition *(bottom left)* will be completed and occupied by fall, 6. An addition to the Radiation Therapy Department will be completed and occupied about March, 1976 *(arrow)*.



ig. 2 Ellis Fischel State Cancer Hospital and most of the 40-acre campus in June, 1975. The buildings are *(right to* the State Cancer Hospital and its new wing, which was about 50% completed; the Cancer Research Center's J. M. n" Allton Building for laboratory sciences, which was occupied in January, 1975; and the Cancer Research Center's . Green Building.

iated nonprofit institution, the Cancer Research
ter (Fig. 2), Ellis Fischel Hospital will fulfill
obligation to the citizens of Missouri in a con-
ing search for solutions to the enigma known
ancer.

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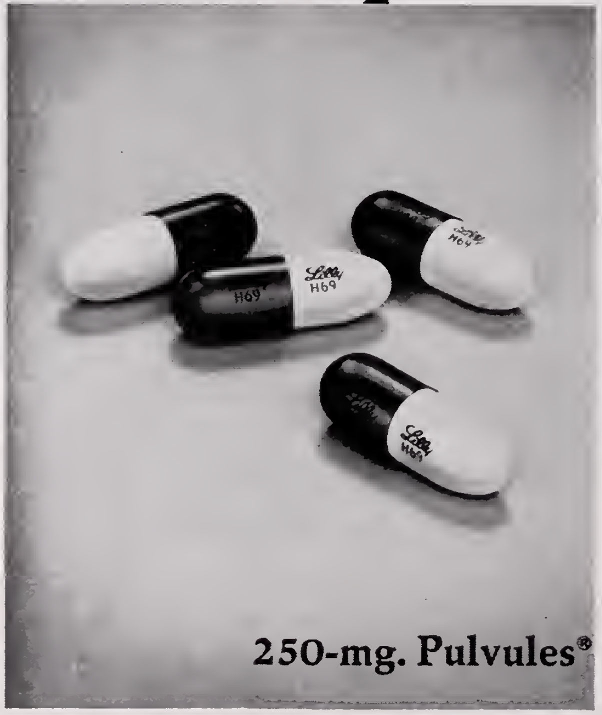

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CARL G. KARDINAL, M.D., NESTOR CANOY, M.D.
and **WALTER RICE,** ***Columbia***

nvasive Carcinoma of the Uterine Cervix

RCINOMA OF THE UTERINE CERVIX remains a lead-i cause of death from cancer in women despite t widespread use of Papanicolaou cytologic s ears.[1] The disease occurs predominately among v men of the lower socioeconomic group, which i he precise group that tends to be less medically s histicated and least likely to have routine pelvic e minations and cytologic smears.[2] The Ellis F chel State Cancer Hospital (EFSCH) evaluates a d treats 40 to 60 new patients with cervical car- c oma per year. This incidence has changed little o r the last 30 years.

The standard therapy for invasive cervical car- c oma at our institution, as well as at most other i titutions, is radiation therapy.[3] Radiation therapy i administered depending upon the stage of the d ease. For stages IA, IB and IIA, using Teleco- b t-60 at 80 cm distance, a dose of 4,000 rads in f r weeks is delivered to the pelvis through AP a l PA fields with the upper level at the iliac bi- f cation and the lower level through the middle o the vaginal canal. The vaginal canal is localized b port films with a radio-opaque probe in the v gina. After a 2,000 rads mid-pelvic dose, a 4 cm n lline block is placed. Essentially, therefore, the r naining 2,000 rads administered are directed to t parametria and pelvic wall (iliac lymph nodes). T e dose to the cervix and vagina is augmented to a high level by a split course of intracavitary r ium therapy using the Fletcher-Suit afterload- i tandem and vaginal colpostats.

The first radium implant is done after the end o the course of external radiation and the second i plant is done two weeks later. A total of 9,000 m to 10,000 mg hours of radium is delivered which gives about 7,000 rads to 8,000 rads to the conventional point A (paracervical). For the late stages of IIB, IIIA and IIIB, external radiation to the whole pelvis with Telecobalt-60 includes a periaortic field through AP and PA fields. The total dose to the periaortic nodes is 4,500 rads in four and one-half weeks, and the dose to the pelvis is 5,600 rads in five and one-half weeks. No midlane block is instituted. This will deliver a homogenous dose to the pelvis and periaortic area. Because of the high dose already delivered to the rectum and the bladder, however, there is a definite limitation to the augmenting dose to be delivered by the intracavitary radium. Therefore, only one intracavitary radium is applied to a dose of 4,000 mg to

In this study, the authors evaluate 185 patients treated with radiation therapy for invasive cervical carcinoma. Each case has been analyzed in terms of response to therapy, time to recurrent disease and survival. This study will form an historic data-base upon which prospective studies for better therapeutic management will be developed.

Dr. Kardinal is Chief of Staff and Director of Internal Medicine, Dr. Canoy is Director of Radiation Therapy and Mr. Rice is a Laboratory Technician at the Ellis Fischel State Cancer Hospital and Cancer Research Center.

This investigation was supported in part by Public Health Service Research Grant CA-08023 from the National Cancer Institute.

TABLE 1
FIGO STAGING OF CARCINOMA OF THE CERVIX

Stage
0: Preinvasive carcinoma or carcinoma in situ.
I-A: Preclinical invasive carcinoma confined to the cervix.
I-B: Clinically apparent lesion confined to the cervix.
II-A: Extends beyond the cervix involving upper vagina.
II-B: Involves parametria, but does not extend to the pelvic wall.
III-A: Involves lower third of the vagina.
III-B: Extends to the pelvic wall, any lesion which causes ureteral obstruction.
IV-A: Extends beyond the true pelvis or involves the mucosa of the rectum or bladder.
IV-B: Metastases outside the pelvis.

TABLE 2
REASONS FOR ELIMINATION FROM THIS STUDY

Total new patients 1969-1973 with stage I-A to IV-A	208
Second primary tumor	8
Non-tumor related death	3
Did not complete therapy	3
Lost to follow-up	1
Treated with surgery alone	7
Treated with surgery plus R.T.	1
Total patients evaluable	185

TABLE 3
HISTOLOGIC TYPES OF CERVICAL CARCINOMA

	Cases	*%*
Epidermoid	161	87
Adenocarcinoma	13	7
Undifferentiated	9	5
Mixed epidermoid and adenocarcinoma	2	1

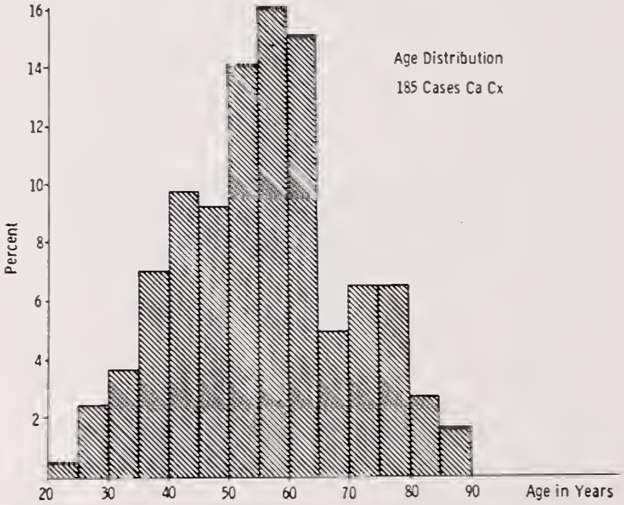


Fig. 1 Age distribution of 185 new patients with cervical carcinoma treated at EFSCH during the period of Jan. 1, 1969 to Dec. 31, 1973.

5,000 mg hours giving an additional 3,000 rad to 4,000 rads to point A. The risk of forming a ves o- or recto-vaginal fistula in these cases, therefor is high compared to the first method of treatment In stage IVA, treatment is completely by exte al Telecobalt-60 and the dose level is pushed to to r- ance: 5,000 rads to the periaortic nodes and 7 00 rads to the pelvis with reducing fields.

Staging at diagnosis has been the single most i- portant prognostic factor.[4] Our institution util the standard FIGO staging system (Table 1). utilizing this staging system, high risk groups v reference to relapse or death or both from t disease can be identified.

The objects of this study are (1) to identify e high risk groups in our own patient populatio t the EFSCH and (2) to utilize this historic c a base for prospective studies aimed at better m agement of high risk patients.

Materials and Methods

All new patients treated with radiation ther y for invasive cervical carcinoma during the pe d of Jan. 1, 1969 to Dec. 31, 1973 were evaluat . This period was selected because it is recent a factors, such as methods of treatment and supp ive care, would be standard. The period also s selected because all patients treated would have t least 18 months followup at the time of the anal s of the data.

All records of the patients were reviewed, a clinical staging was correlated with patholo staging. The standard staging procedure for all tients with carcinoma of the cervix at the EFS includes pelvic examination under anesthesia, c toscopy, sigmoidoscopy, intravenous pyelogra and, now, colposcopy.

Actuarial survival by FIGO stage at diagno

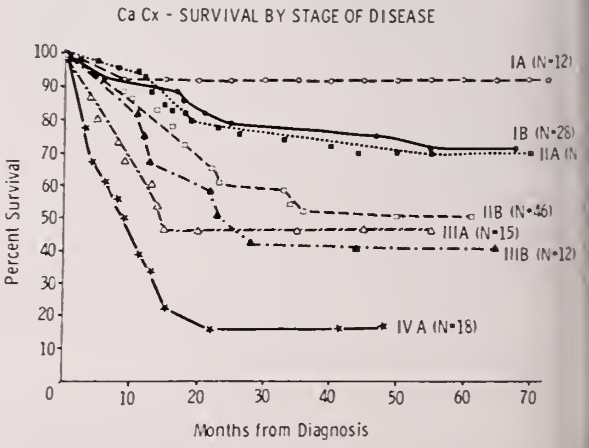


Fig. 2 Survival of patients with carcinoma of the cer by FIGO stage at diagnosis.

ıs plotted, the time and site of documented recur- ıce were noted and the risk of recurrence by ge of disease was calculated.

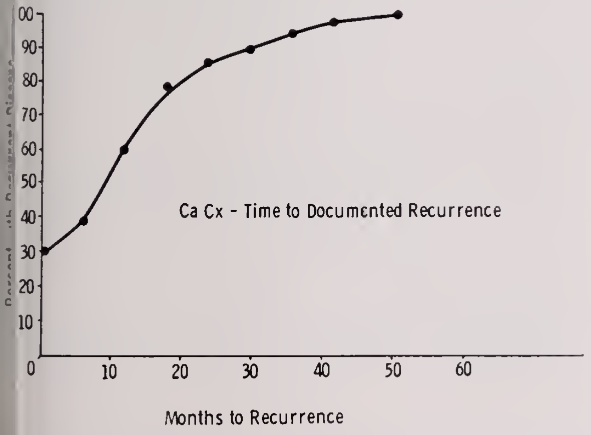
SULTS

As can be seen in Table 2, 208 new patients with asive cervical carcinoma were evaluated and ated at the EFSCH during the period of Jan. 1, 39 to Dec. 31, 1973. Twenty-three patients were minated from the study and the reasons for elimi- ıion are listed in Table 2. The resultant 185 pa- ıts formed a reasonably homogeneous group. All these patients were treated with radiation ther- y alone as primary therapy for stage IA to IVA ease. It is notable that only one of the 208 pa- ıts has been lost to followup and our Social Ser- e Department is actively trying to get informa- ı on this patient.

The histopathologic types of cervical carcinoma listed in Table 3. Although the number of non- dermoid cases was small, it seemed that their ıical behavior was similar to the 87% of cases t were epidermoid carcinoma.

The age of patients at diagnosis ranged from 21 36 years with the majority of patients being from to 65 years of age (Fig. 1). One third of the ients were less than 50 years old at the time of gnosis.

urvival by stage at diagnosis is illustrated in ble 4 and Figure 2. Both five-year survival and dian survival correlate with the stage at diag- is. Patients with stages IA, IB and IIA all had dian survivals in excess of 60 months (five rs). Patients with stages IIB, IIIA, IIIB and IVA had median survivals of less than five years, and ients with IIIA, IIIB and IVA had median sur- als of less than two years.



ig. 3 Time from completion of therapy to documented ırrence. Note that 30% of patients who developed a ırrence had no disease free interval.

Sixty-six patients had a documented recurrence of their disease during the study interval (Fig. 3). Sixty percent of the recurrences appeared within the first year and 86% within two years. Greater than 90% of all recurrences were within three years of the original diagnosis and treatment.

Greater than 70% of recurrences related to a failure to control the local disease by the primary therapy (Table 5). Less than 30% of documented recurrent disease was due to distant metastases.

TABLE 4

SURVIVAL BY STAGE OF DISEASE

Stage	*Number*	*5-Year Survival (%)*	*Median Survival* (MONTHS)
I-A	12	92	>60
I-B	28	72	>60
II-A	54	70	>60
II-B	46	50	50
III-A	15	46	14
III-B	12	40	23
IV-A	18	16	9
	185		

TABLE 5

SITE OF RECURRENCE IN 66 PATIENTS WITH DOCUMENTED RECURRENCE

Local recurrence	48*
Cervix and vagina	35
Regional lymph nodes	9
Rectum	2
Bladder	2
Lung	5
Bone	4
Liver and/or kidney	6
Distant lymph nodes	2
Other	7
Died of disease at outside hospital, site of recurrence unknown	24

* 20 of this 48 with local recurrence had no true tumor free interval.

TABLE 6

THE INCIDENCE OF RECURRENCES AND DEATHS FROM DISEASE BY INITIAL STAGE

Stage	*Number*	*Recurrences*	*Dead From Disease*
I-A	12	1 (8%)	1 (8%)
I-B	28	10 (36%)	8 (28%)
II-A	54	20 (37%)	16 (30%)
II-B	46	26 (56%)	24 (52%)
III-A	15	8 (53%)	8 (53%)
III-B	12	9 (75%)	8 (67%)
IV-A	18	15 (83%)	15 (83%)

Over 40% of patients who failed because of local recurrence never had a well documented, tumor-free interval. Of the 89 people developing a documented recurrence during the study period, 80 (90%) died of their disease (Table 6).

Discussion

The high incidence of cure in the early stages (IA, IB, IIA) of carcinoma of the cervix is attributed to the tolerance of the uterus and adjoining vagina to high dosages of radiation (25,000 rads to 30,000 rads) which can be administered locally by implantation of radium or other radioactive materials. The radiation falloff is such that the radiation received by the adjoining normal structures, i.e., the urinary bladder and recto-sigmoid, is well tolerated. The concomitant external radiation with high energy given to the whole pelvis (parametria and pelvic nodes) destroys the minimal cancer beyond the reach of the implant and is designed so that the total radiation given will not exceed the tolerance of the urinary bladder and recto-sigmoid.

In the late stages where the disease is still localized in the pelvis, the local failure is due to the inability to deliver a high dosage of radiation without compromising the adjoining normal structures. Failure also is compounded by subclinical metastases to the periaortic nodes and visceral organs. As is documented in the results section, the dominant reason for treatment failure is failure to control local disease.

Although cures of recurrent disease after radiation therapy have been well documented,[5] 90% of the patients in this series, regardless of their initial stage, who developed a recurrence died of their disease during the study interval. This strongly implies that if the disease is not eradicated by the initial treatment the chance for cure is small.

Our data confirm the results of others that patients with advanced disease, i.e., stage IIB, IIIA, IIIB and IVA, are at significantly higher risk of recurrence and death.[4] It also may be concluded from the above that if survivals in this high risk group are going to improve, therapy during the initial phase of the disease must be reevaluated. It seems reasonable, perhaps, that treatment with chemotherapy immediately after radiation therapy at a period when there is a minimal tumor burden may be of benefit.

To date, chemotherapy of advanced carcinoma of the cervix has been of limited usefulness. All
lating agents, such as cyclophosphamide, m
phalan, chlorambucil and nitrogen mustard, ha
produced response rates in the range of 20% to 25
Methotrexate and 5-fluorouracil also have produc
transient responses. Other agents which have a
peared to be useful in the treatment of carcino
of the cervix include bleomycin and adriamyc
Blum *et al*[7] have reported a worldwide respo
rate of 21% with bleomycin, but this has not be
confirmed by cooperative studies in the Unit
States. Although limited data are available
adriamycin, it does seem to be an effective drug.[8]
Reasoning in parallel with the recent National S
gical Adjuvant Breast Protocol utilizing L-phen
alanine mustard (L-PAM) in breast cancer,
seems that a similar protocol might be effective
carcinoma of the cervix.[10] Melphalan (L-PAM)
a single agent has not been proved to be ov
whelmingly successful in the treatment of brea
cancer, but the data reported in its use as a su
gical adjuvant chemotherapeutic agent, when the
is minimal residual disease, have demonstrated d
creased relapse rates in premenopausal women wi
breast cancer. Since oral alkylating agents are we
tolerated, we plan to evaluate L-PAM as a radiati
therapy adjuvant in patients at high risk (stages II
IIIA, IIIB, IVA).

This study may ultimately serve as an histor
control for the evaluation of the chemotherap
radiation therapy program.[11]

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JOHN S. SPRATT, JR., M.D., M.S.P.H., *Columbia*

ancer Control: Intervention or Prevention?

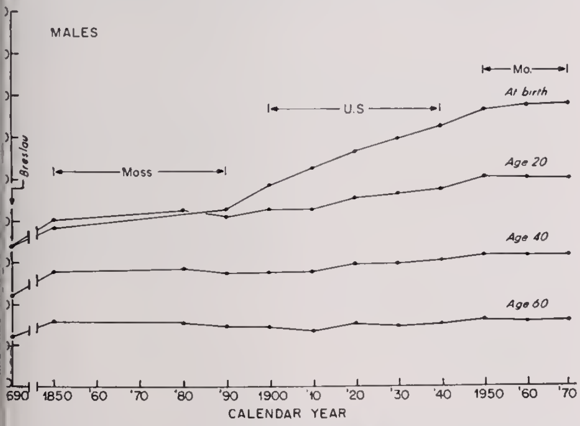
E IMPACT of various complex activities which are dical, environmental and technological on the lth of a population is often difficult to assess. e complexity of human systems and the numer- variables that affect longevity and disease pat-ns often preclude hypothesis testing in the usual se recognized by the scientific method and the tisticians. Where data may be collected with ac-otable accuracy, the researcher is left with a chal-ge to identify associations. The identification of ociation patterns still does not establish cause-l-effect relationships with finality. One might sider the health benefit associated with a single ysician and a single patient or of the association tween the entire health system and the health of entire population or of the impact of environ-nt, technology and cultural norms over which health industry has little control on health and gevity.

n 1966, we published a report on the trends in longevity of Missourians dating from the first ilable life tables through the 1960 census.[1] This er updates that report on the basis of the 1970 sus. The data are given in Figs. 1 and 2 and in bles 1 and 2. As is evident, the longevity of wom- continues to increase, but the longevity of men continuing a pattern of nonimprovement or even ownward trend as noted in the period between 1950 and 1960 census. This trend suggests that current impact of the health system upon the male population of Missouri is either decreasing the longevity of males or else the environment in which the male functions is adversely affecting his longevity to a degree greater than is being countered by the intervention of the present health system.

The causes of death in 1964 and 1974 are listed in Table 3 to show that the causes of death have not changed significantly. Many of these causes are related to nutrition, adverse environment, economic and social conditions and aging, none of which has visibly effective prevention programs for the general populace. This lack of emphasis on prevention has brought criticism of contemporary medical schools and the existing health systems. To quote from Wolfe:[2]

> Another important but related reason why many preventable diseases haven't been prevented, however, is lack of information at the lay level. Although the role of unsatisfactory nutrition, overeating, dangerous consumer products and the increasingly polluted environment in causing disease needs more research, even when studies have been done, their results are rarely translated from the foreign language of science into simple English.
>
> . . . most disease is preventable and, once research is done and people informed, the diseases will require no further "treatment beyond their political solution."

To bring these observations down to the prevention of cancer in a state cancer control program, we published a review article last year entitled



ig. 1 Trends in the longevity of Missouri males dating m the first available life tables through the 1970 census.

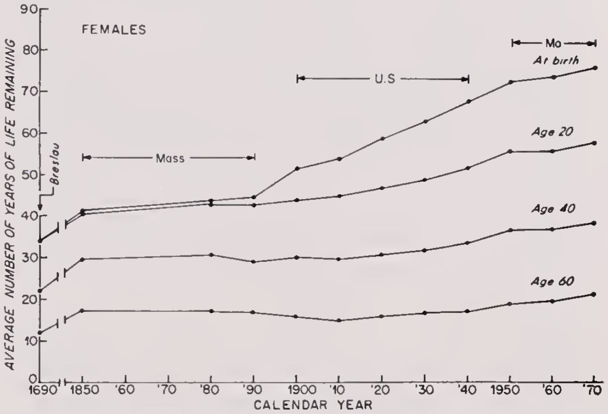


Fig. 2 Trends in the longevity of Missouri females dating from the first available life tables through the 1970 census.

TABLE 1

CHANGING LIFE EXPECTANCY (YEARS) AT DIFFERENT AGES AMONG THE POPULATION OF MISSOURI BETWEEN 1960 AND 1970—MALES

	*1959-1961**	*1970*†	*Change*
White males			
At birth	67.94	67.70	-0.24
Age 20	50.60	50.00	-0.60
Age 40	32.10	31.70	-0.40
Age 60	16.21	16.00	-0.21
Non-white males			
At birth	60.72	60.00	-0.72
Age 20	44.80	43.70	-1.10
Age 40	27.76	27.80	+0.04
Age 60	14.58	15.30	+0.72

* State Life Tables: 1959-1961, Department of Health, Education and Welfare Public Health Service.
† Current Missouri Life Tables.

TABLE 2

CHANGING LIFE EXPECTANCY (YEARS) AT DIFFERENT AGES AMONG THE POPULATION OF MISSOURI BETWEEN 1960 AND 1970—FEMAL

	*1959-1961**	*1970*†	*Cha*
White females			
At birth	74.76	75.70	+0.
Age 20	56.80	57.40	+0.
Age 40	37.69	38.30	+0.
Age 60	20.09	21.00	+0.
Non-white females			
At birth	65.79	68.60	+2.
Age 20	49.46	51.90	+2.
Age 40	31.43	33.80	+2.
Age 60	17.52	19.80	+2.

* State Life Tables: 1959-1961, Department of Health, Educat and Welfare Public Health Service.
† Current Missouri Life Tables.

"Your Behavior and Cancer" and solicited physician comment.[3] The only critical comment was published as a letter to the editor[4] with a reply. A number of physicians have distributed this article to patients as a course of action that, if followed, should reduce an individual's chance of acquiring cancer. The major cancers afflicting Missourians as reported in the Missouri Cancer Registry Second Progress Report of April, 1975[5] are largely preventable. In fact, in a personal conversation with Dr. Frank Rauscher of the National Cancer Institute, he confirmed that his staff estimates that 80% of the cancers probably have environmental causes and may well be preventable. He further stated that he had been unsuccessful in interesting anyone in t country in running an evaluative prevention pr gram.[6]

In the Missouri Cancer Control Program, t seeds at least have been sown for what might eve tually develop into a statewide cancer preventic program. However, it would never succeed withou the knowledgeable and determined support of ph sicians, other health professionals, the Missouri D vision of the American Cancer Society and th media. The countervailing forces are too great t be overcome without near total commitment. Thes countervailing forces are mostly commercial an only one reference needs to be cited to make th point. However, this reference has an extensive bit liography. The reference is entitled *Subliminal Se duction.*[7]

The longevity of men in Missouri has not improved during the last two decades and may have declined for some age groups. Causes are complex, multiple and, perhaps, elusive. Sufficient emphasis is not being placed on preventive conduct. Among other influences, the persuasiveness of the advertising industry has motivated many people to follow behavior patterns detrimental to their health. Even though effective health education programs are needed, only the people as individuals can change their behavior patterns to lessen the possibility of developing cancer.

Dr. Spratt is Director of the Cancer Research Center and Chief Surgeon at Ellis Fischel State Cancer Hospital. This investigation was supported in part by Clinical Cancer Training Grant CA-08018 from the National Cancer Institute.

TABLE 3

CAUSES OF DEATH AMONG MISSOURIANS*

	1964	*1974*
Cardiovascular diseases (cardiac and peripheral)	20,492 (42.9)	20,566 (40.7
Cancer	7,730 (16.2)	8,980 (17.8
Cardiovascular disease (cerebral)	6,130 (12.8)	5,836 (11.6
Accidents	2,807 (5.9)	2,424 (4.8
Pneumonia	1,749 (3.6)	1,390 (2.8
Diabetes mellitus	788 (1.6)	961 (1.9)
Malformations and diseases of early infancy	1,787 (3.7)	630 (1.2)
Suicide	544 (1.1)	621 (1.2)
All other causes	5,768 (2.1)	9,096 (18.0)
	47,795	50,504

* Missouri Vital Statistics 1974. Missouri Center for Health Statistics, Division of Health, Jefferson City, Mo., 1975.

his book contains ample documentation of the efctive vigor of the American advertising industry a its almost amoral persuasiveness in motivating pple to follow behavioral patterns and consume comercial products detrimental to their health. ch of the persuasive effect is subliminal and is dected at the subconscious, leaving no conscious dense against the message. Every physician should re this book in order to appreciate what he is cpeting against when he attempts to persuade a pent to cut down his smoking, drinking, excessi eating, sun bathing and other bad habits.

he fact facing us is that the longevity of males nMissouri has not improved over the last two dades and may have actually declined for some g groups. The basic question raised is whether lfe is right in saying that we may be adding onorbidity and premature mortality by failing to e sufficient emphasis on preventive conduct.[8] d research demonstration studies are needed to ve the value of all types of interventions. Efeive prevention requires more effective health cation.

s Wolfe has documented, there is an important e in future health priorities in the entire field f ffective public education in basic health maineance practices. This has to start at a very young and may require substitutions for many cure ly accepted social practices, such as advertising ealthy products, improving physical fitness hugh a system of aerobic exercises and emphasizn nutrition. In short, there needs to be more tied evaluations of preventive approaches to th maintenance as well as closer assessment of rvention methods in large populations. This is icularly true for men in Missouri who have hvn no significant improvement in longevity for ears while female Missourians have been doing e well.

nother trend observed in the disease pattern of sourians and which is being monitored is the etive annual incidence of new cancer cases seen the Ellis Fischel State Cancer Hospital and Cane Research Center. These trends were last reced in 1970.[9] At the time the observations were e, the incidence of skin and lip cancer had declined in frequency while cancers of the respiratory system, blood forming organs, urinary tract and lower digestive tract had increased. The current data on these trends are given in Table 4.

TABLE 4

RELATIVE ANNUAL FREQUENCIES OF CANCERS TREATED AT THE EFSCH COMPARING 1965-1969 TO 1970-1974*

Site of Cancer	*Relative Annual Frequencies* 1965-69	1970-74	*Percent Change in Frequencies*
Lip	0.62	0.52	– 0.10
Skin	42.03	31.20	–10.83
Blood forming	3.46	5.23	+ 1.77
Lower digestive	6.43	7.19	+ 0.76
Primary not specified	4.00	5.60	+ 1.60
Respiratory system	8.74	11.47	+ 2.73
Urinary	2.47	2.35	– 0.12
Endocrine	0.33	0.45	+ 0.12
Musculoskeletal	0.47	0.58	+ 0.11
Soft tissue	0.97	1.15	+ 0.18
Accessory digestive	0.83	0.93	+ 0.10
Oral cavity	3.32	3.17	– 0.15
Salivary	0.40	0.39	– 0.01
Upper digestive	2.01	1.77	– 0.24
Nervous system	0.09	0.27	+ 0.18
Special sense	0.09	0.12	+ 0.03
Breast	9.05	11.90	+ 2.85
Cervix	7.51	7.99	+ 0.48
Endometrium	2.58	2.37	– 0.21
Male genital	2.80	2.72	– 0.08
Ovary	0.97	1.79	+ 0.82
Vulva-vagina-uterus	0.85	0.84	– 0.01

* Spratt, J. S., Jr.: Relative Annual Frequencies of Cancers, 1940-1970. Mo. Med. 67:835, 1970.

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and* CORINNE FARRELL, M.D., *Colum ia

Screening Asymptomatic Women for Breast Canc r

The Missouri Breast Cancer Detection Demonstration Project at the Cancer Research Center in Columbia officially began operation on July 1, 1974. The basic contract agreement with the National Cancer Institute and the American Cancer Society (NCI-ACS) was to screen a minimum of 5,000 asymptomatic, 35-to-74-year-old women annually for each of two years. This group of 10,000 or more can be followed by annual examinations for a total of five visits, and then by letter for an additional five years. On May 15, 1975 after 10½ months of operation, the 5,000th participant was screened. Now in quarters twice as large as the original area, the Project began immediately to rescreen this group plus scheduling an additional 5,000 new participants. At the time of this writing (September, 1975), we have completed the initial study on more than 7,000 women and have another 7,000 on the appointment list.

It is apparent that present facilities and personnel are inadequate to respond to all who seek this examination. Our hope is that this and the other projects can so identify high-risk individuals or groups and so refine present diagnostic methods that all who need screening will receive it at an acceptable cost-benefit ratio.

Our initial report[1] in Missouri Medicine described our long-term objectives and the techniques of detection. At that time, we indicated that we would report our continuing experience. This is the report that deals with the findings in the first 5,000 participants, all of whom have had the complete studies. These data are preliminary and subject to revision.

The reports on the disposition of the biopsy cases represent responsible replies from laboratories, physicians or the participant herself. However, not all slides have been reviewed by the designated project pathologist. These studies are underway and will be accomplished. The crucial nature of this histologic review by a number of persons is a recognized fact. To complete this review for the hundreds of women involved will require time, but the ultimate goal of the project is to review every biopsy case. In the future, the report of the hospital pathologist, whose opinion affects the therapeutic management of the case, will be our point of re ence in reporting “benign” or “malignant.” It thus, too early to form conclusions. It is not early to begin searching for trends or indica that might help direct the further efforts of this any other similar project.

Each of our three detection modalities will described by the physician responsible for the c duct and reporting of such procedures. We f that these methods are fulfilling the project's jectives and, at this time, we plan to continue t combination of methods. They will be presented the order in which they are accomplished by participants with the thermographic study be first (requiring a preliminary period of coolin followed by the mammography and concluded the physical examination.

Thermographic Examination

We are still using Polaroid black-and-white fi as a thermal pattern presentation rather than t 70 mm film. The lack of gray scale availabili processors, equipment and personnel and the d tance of screenee travel account for the use the Polaroid presentation. Only after the therm gram is read is any clinical information or ot modality result available to the thermography rea er, and then only at the weekly conference. T “independent reading” reading poses a true init test of this modality in this type of screening pr gram. Thermographic interpretation is still bas on asymmetry of the background breast temper ture and the vascular patterns as well as patte difference, areola heat, contour differences and t edge and shrink sign.

The definitive role of thermography in ma screening for breast cancer has yet to be ful ascertained. Thus far in this country, there are t many conflicting studies with varying expertise an results to say nothing of a variety of examination presentations and machines. The lack of canc specificity and sensitivity further complicates t true picture of the validity of thermographic us Only in ten years will we know the strength an weaknesses of breast screening modalities. The ke then, is continued intelligent use, thus enhancin

Now in its second year of existence, the Missouri Breast Cancer Demonstration Project has screened more than 7,000 asymptomatic women for breast cancer. Thermography, mammography and clinical examination are the modalities employed. Indications are that these three modalities used in tandem provide the highest degree of accuracy in the diagnosis of minimal breast cancer.

Dr. Rodes is Project Director, Missouri Breast Cancer Demonstration Project, and Dr. Blackwell is Project Consultant in Radiology (Xeromammography) at the Cancer Research Center. Dr. Farrell is Associate Professor, Department of Radiology, University of Missouri School of Medicine and Project Consultant in Radiology (Thermography) at the Cancer Research Center.

This investigation was supported in part by General Research Support Grant FR-05618 from the National Institutes of Health.

o interpretation expertise and standardizing exaination, machines and technicians' procedures, a well as the printout. These improvements in the stems of quality control will truly evaluate this dgnostic tool in this specific endeavor.

n the Columbia project, we have found 30 cancs in 5,000 asymptomatic women. The thermogphic examination can be interpreted as being "satisfactory," "normal" or "abnormal." There is n "cancer" option for the result of the interpretath. The thermogram was abnormal in 13 cases of t 27 primary cancers. Two screenees were given a ormal reading but were asked to return early for r xamination because of an asymmetry in the heat ptern of the breast, which later was proven to be n lignant in both cases.

Vhen the remaining false negatives were read, fr were reread as negative again, three were rerd as abnormal and represent under-reading of t examination. In two instances, the thermogram s not available for rereading since the participt had been transferred to another project.

ll three local operative site chest wall recurrces were not displayed. We believe that by hav- three different increased brightness controls, rmograms of this area should increase our ability identify chest wall recurrences. These recurces were all found on physical examination and, o course, were not seen or tested by mammograp. A total of 201 biopsies or aspirations on 198 ients was requested because of findings on the psical examination or on xeromammography exination or both. No biopsy recommendation on abnormal thermogram alone is done in this prom. There were 149 biopsies productive of ben breast disease. Of these, 24 examinations were ed as abnormal. The thermographic examination ults for the interval cancers that have occurred discussed elsewhere.

he assessment of false positives using the dality of thermography cannot be made for ten rs in light of what we know of the clinical beior of breast cancer. What is thermographically ormal in June of 1974 may not manifest itself other modalities as detectable disease. One of important uses of the thermographic examinan is the sequential changes that may be seen ing this five-year interval. Also, because of the a of specificity for other breast disease, "abmalities" may be present and, therefore, may represent a true false-positive rate. Thirty-five cent of our screenees have abnormal thermoms or, in other words, there are varying degrees breast background heat, asymmetry of vessels, asymmetry of areolar heat, etc. Because of the lack of suspicion on other modalities, however, they are not biopsied, so the presence of disease is not proven or disproven. Twenty percent of screenees are recalled prior to the annual screening date for repeat thermograms only. Thus far, we find that the "cluster of calcification" mammogram many times does not have an accompanying abnormal thermogram on that side.

There is no question that thermography works best in combination with the physical examination and mammography. When each modality is read independently without knowledge of any other modality findings or results, we then bring the positive-finding cases to a once- or twice-a-week consultation meeting in which all modalities are reviewed. On several occasions, thermography and mammography findings have resulted in biopsy recommendation rather than an early recall or an annual rescreen. It also reinforces what otherwise might be an indeterminate decision for biopsy. Our mammographer wishes to review his xeroradiography study on each "abnormal" thermogram examination, and we do so at this weekly conference. This allows revisions of recall dates and consideration of biopsy. While it is time consuming, it renders the best consultation on each modality or combination of modalities that we can make for each individual screenee.

Currently, we believe that thermography should be an integral part in the project for finding occult cancer. Not all breast cancers "send out" a detectable signal. If they did, they would be picked up with our current detecting systems. So, a false-negative rate of 30% is acceptable, considering experience and systems available.

An important problem presents itself in the terminology we have instituted and are using, i.e., "abnormal." This upsets both the patient and the physician. The use of "X, Y and Z," as Dr. Richard Byrne of Milwaukee suggests, would emphasize the nonspecificity and the inability to discriminate between benign and malignant disease, and it would allow us to avoid the use of the word "abnormal" when the other two modalities were negative. Also, the use of the word "normal" has not allowed avoidance of a false sense of security for all concerned—the patient, the referring physician and the thermographic reader.[2]

To date, we believe that the first role of thermography may be to assist mammography so as to influence the mammographic diagnosis of benign disease and of questionably suspicious thermographic lesions with a normal mammogram. Sixty-three percent of our screenees with cancers had abnormal thermograms either on the initial or on the reexamination interpretation. Twenty-six percent had normal thermographic readings according to present criteria of interpretation. Eleven percent are not available for review.

The second role of thermography is in the follow-up examination of the cancer-proven screenee for another primary or metastatic lesion in the remaining breast. The current figures of a possible second or contralateral breast cancer, whether it be primary or metastatic in the single-breasted woman, are many times that of the two-breasted woman, and thermography's use on a biyearly basis is a cheap, noninvasive, non-time-consuming, drugless method of followup monitoring.

Third, thermography is a method for follow-up on the operated side. This is a questionable use because physical examination should show recurrence if the patient is being seen by her physician. Nonetheless, "stitch abscesses" have been found th mographically to be recurrences. We intend to clude this observation in our project to incre the quality control of the examination and to prove our technical and interpretation expertise.

TABLE 1

BIOPSIES BASED ON BOTH CLINICAL (PHYSICAL) EXAMINATION AND MAMMOGRAPHY

Number cases biopsied/combination clinical (03) and mammography (04)	31
Interpreted benign—report benign	26
Interpreted cancer—report cancer	4
Interpreted cancer—report benign	1
Degree of accuracy	30/31

XEROMAMMOGRAPHY

The majority of the biopsy and aspiration rec mendations were made for what were thought be benign masses. This mammographic impress proves to be quite reliable.

The cause of greatest diagnostic challenge mammography is a cluster of punctate calcificati without associated mass or architectural distorti There is a high ratio of benign to malignant dise in this group. However, five of the cancers w recommended to have biopsy early on the basis calcification suspicious of malignancy without mass being evident on mammography.

Of the 30 reported cancers, three were chest w recurrences following mastectomy and were amenable to x-ray diagnosis. Twenty-four of 27 primary cancers were seen on the Xeromamm grams. Twenty of these cancers were not detect on physical examination. Four of the 27 prim cancers were palpable and also detected on ma mography (Table 1).

Of the 24 primary cancers seen on mammograp 22 were diagnosed preoperatively as either mal nant-appearing lesions or as calcifications hig suggestive of malignancy. Two of the biop proven malignant lesions were incorrectly di nosed to be "probably benign" densities on ma mography.

It should be reemphasized that mammogra should not replace a good physical examination a that lesions are not always evident on the mam gram. A negative x-ray report cannot guarantee participant that she does not harbor an undete able cancer.

THE CLINICAL EXAMINATION

The clinical examination is carried out by train nurse-clinicians. They receive lectures in bre anatomy, physiology and pathology, which a followed by personal instruction in the skill physical examination. The first hundred or so e aminations are done under direct supervision. F lowing this, most positive findings, but not all, a checked by a project physician. If a physician not readily available, the findings are recorded such to be reviewed later by the senior staff.

Forty-one of the 187 reported cases were biopsi

TABLE 2

BIOPSIES BASED ON CLINICAL (PHYSICAL) EXAMINATION

nber cases biopsied/clinical (03) suspicion one	41
Cical benign—report benign	34
Cical cancer—report cancer	3
Cical cancer—report benign	4
D;ree of accuracy	37/41

b ause of clinical signs alone. In 37 of these, the c ieal impression and the reported diagnoses were i greement. The remaining four cases were called pbably malignant" clinically, but were benign h ologically (Table 2).

Vhen biopsy was done on lesions identified both b clinical examination and mammography, the acc acy rate was higher (Table 1).

'his degree of accuracy should be expected. A t ior that is clinically evident is not an "early" st ge. Forty percent will have metastases to region- odes by the time a breast cancer has reached 1 m to 1.9 cm. When the tumor is 2 cm to 2.9 cm, 5 will have metastases.[3]

'his is *not* occult or minimal breast cancer and s problem that can be detected not only by a p sician or nurse-clinician or both, but by the p ticipant herself, as well as others. The time of d gnosis must be moved back beyond this. Even s a careful, systematic, deliberate clinical exami- ion remains an integral part of any effort to ntify breast cancer in the asymptomatic woman.

I ERVAL CANCERS

Every project must accept the fact that some ast cancers will develop in screened participants ween their annual visits. At the time of the last mination in the project, some cancers might not b discovered because of limitations of man and chines. Some are not evident even in retrospect, a l there are some breast cancers whose doubling- ti e growth rate is such that they can begin and b ome clinically obvious in the 12-month period less. We have had three interval cancers report- There may well be more. Table 3, "Section indicates the initial interpretation of each of the ee examination modalities; "Section B" indicates t interpretation of the same studies after the re- its of the diagnosis of cancer were known.

S MMARY

A review of the preliminary figures for the first v r are as follows:

TABLE 3

INTERVAL CANCERS

Mode[1]	Initial Reading (A) 03	04	05	Rereading (B) 03	04	05
Case #1	–	–	–°	–	–	–
Case #2	–	–	–†	–	–	+
Case #3	PB‡	–	–	–	–	–

[1]Mode = 03 physical examination, 04 mammography, 05 thermography.
– = Negative for cancer.
+ = Abnormal.
° Patient given one year annual recall; described as having "focal areas of heat" on left breast.
† Patient given an early recall because of asymmetrical reading.
‡ PB = "Probably Benign"; biopsy deferred pending consultation.

In the first 5,000 cases, 201 biopsies or aspirations or both were recommended in 198 participants. This is a biopsy rate of 4%. About 20% overall are recalled prior to the 12 months reexamination to have one or more modalities repeated because abnormalities at the previous examination were not considered sufficient for biopsy. The remaining 76% of the participants received a reexamination date for one year. At this time, we have received followup information on 90% of the suggested biopsies. Some projects have indicated difficulty in obtaining physician cooperation. This problem has been named "noncompliance." It indicates that the suggestion from the project for further investigation of an abnormal finding is not carried out by the primary provider of medical care. This is not the case in Missouri, and it deserves comment.

It was not expected that all the aspirations and biopsies suggested by our project would be promptly or eventually performed. In our case, 22 of the 201 recommendations were not accomplished. Nineteen were considered "probably benign" by us. Of these, 17 were identifiable by clinical examination. All of these 17 are under close clinical observation by private physicians. In this circumstance, this appears to us to represent the exercise of clinical judgment on the part of the private physician. It represents, at most, a difference of professional opinion regarding the indications for a tissue diagnosis. This should not be labeled "noncompliance." The two cases in which the mass was only detectable on mammography, albeit "probably benign," might be construed as noncompliance. There were three cases which we feel must be considered truly noncompliance. All three had mammographic evidence as a sole basis for recommending biopsy and all three were considered suspicious or suggestive of malignancy. In one case, the participant herself elected to defer biopsy against the advice of her

(Continued on page 701)

GEORGE J. FUCHS, M.D. *d*
OSCAR D. FONSECA, M.D., *Colum a*

Colposcopy

Colposcopy is a clinical evaluation of the uterine cervical epithelium and should be considered an adjunct to the pap smear. It also is utilized in the study of vaginal and vulvar lesions. However, we will confine our discussion primarily to the cervix. This relatively new and more accurate diagnostic modality has recently been added to the diagnostic armamentarium of the Ellis Fischel State Hospital. It offers us a more complete evaluation and early diagnosis for malignant and other lesions of the cervix uteri in their preclinical stages.

The colposcope (colpo = vagina, skopeo = view)[1] is used to examine the cervix by means of a "microscope." The magnification utilized on the colposcope is usually 14 times. It should not be confused with culdoscopy which is viewing the internal pelvic organs by the introduction of an endoscope through the posterior vaginal wall and cul de sac.

Cytologic screening or the pap smear is well established today as the best screening procedure for the detection of preclinical carcinoma of the cervix. The accuracy as reported in the literature is between 70% and 90%. Achenbach *et al*[2] reported 70% accuracy whereas Navratil *et al*[3] found 88.5% and Cuyler *et al*,[4] 89.4%. In general, the degree of accuracy depends upon the technical quality of the smear and experience of the pathologist. Cytologic screening is strictly a laboratory diagnosis.

Colposcopy is a clinical diagnostic technique t t is currently being utilized throughout the Uni States to supplement information gained by pap smear. The colposcope was first designed Hinselman of Germany in 1925[5] and consists o binocular magnification with built-in, sharply cused light, which permits evaluation of chan in the surface patterns and the terminal vascu network of the cervix. The instrument has be widely used for almost 50 years in mid-Euro some Latin American countries and Australia primary evaluation of the cervix uteri. Its utili tion in the United States is only 10 to 15 years o but it is gaining universal popularity. Part of t delay for its use in the United States may be tributed to the wide acceptance, accuracy and ea of the pap smear, even though it has its limitatio

The colposcope, too, has limitations. It is es mated that 15%[6] of the patients yield an unsat factory diagnosis because the entire transformati zone of the cervix cannot be fully visualized.

As cited by Hill,[7] Navratil reported a series 55,000 patients who were evaluated by using t simultaneous approach of both pap smear a colposcopy and in whom 838 cases of preclinic carcinoma of the cervix were discovered. He es mated that 729 (87.0%) would be detected cytologic screening alone. Using colposcopy as t only modality, 663 (79.1%) would be diagnose Using *both* methods, 828 (98.8%) were discovere Ten cases were missed by both cytologic screeni and colposcopic examination. These diagnoses we made as incidental findings of the surgical spec mens. The accuracy of the pap smear or the colpo copy examination used alone is approximately 85 When used together, it is about 98.8%.

Transformation Zone

It must be understood from the onset that th *entire transformation zone* of the cervix must b visualized (Fig. 1). The transformation zone where the action and change are located. We mu emphasize, also, that the maximum colposcopi findings consistently correlate accurately with th maximum histological findings.

The transformation zone is that area between th

The Ellis Fischel State Cancer Hospital recently has obtained the colposcope, an instrument which adds a new dimension to the clinical evaluation of the uterine cervix. Coposcopy is considered an adjunct to a pap smear. Diagnostic accuracy of the pap smear and colposcopic examination used in tandem may be as high as 98.8%, according to a report of a large series.

Dr. Fuchs is Consultant in Gynecology and Dr. Fonseca is a Fellow in Surgical Oncology at the Ellis Fischel State Cancer Hospital and the Cancer Research Center.

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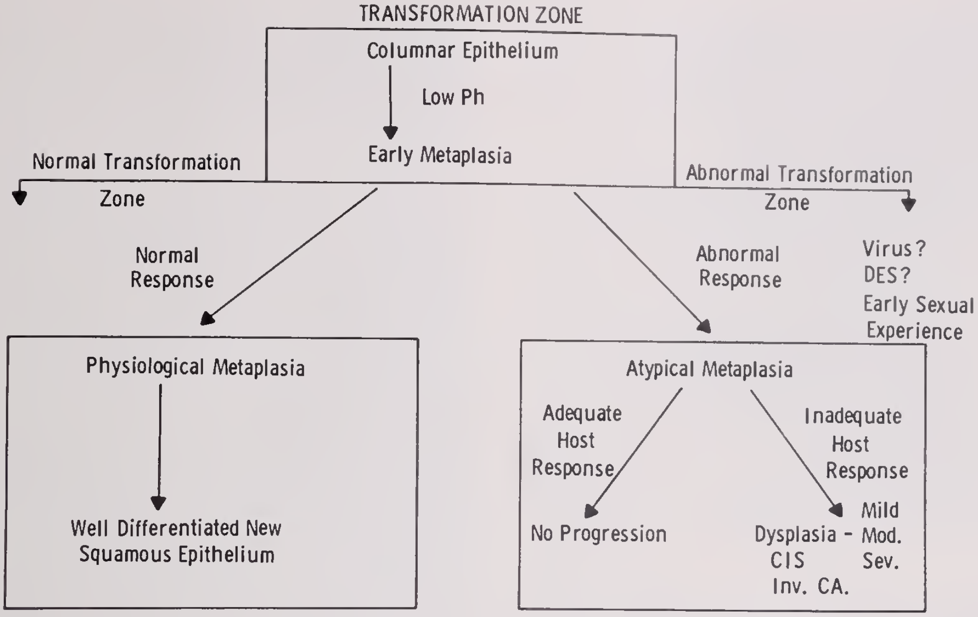

TRANSFORMATION ZONE
Columnar Epithelium
Low Ph
Early Metaplasia
Normal Transformation Zone
Abnormal Transformation Zone
Normal Response
Abnormal Response
Virus?
DES?
Early Sexual Experience
Physiological Metaplasia
Well Differentiated New Squamous Epithelium
Atypical Metaplasia
Adequate Host Response
Inadequate Host Response
No Progression
Dysplasia - Mild Mod. Sev.
CIS
Inv. CA.

Presented at Advanced Colposcopic Course at the Medical College of Wisconsin, Milwaukee, Wisconsin
This is a modified version of Adolf Stafl's presentation

Fig. 1

umnar epithelium and the native squamous epi- lium, which also is called original squamous thelium. The transformation zone is the area, refore, where the columnar epithelium has trans- med or is being transformed into new squamous thelium. The *entire* transformation zone must be ualized. In other words, the columnar epithelium ist be visualized internally and the native squa- us epithelium must be visualized externally. The cess of transformation is usually termed squa- us metaplasia. Squamous metaplasia generally urs during three basic time periods: (1) neo- al period, (2) puberty and (3) first pregnancy. Description of the systematic change of the trans- mation zone (Fig. 1) is as follows: the columnar ithelium under the influence of a low or acid Ph dergoes early metaplasia. The early metaplasia take two main courses: a normal response or an normal response.

The normal response continues to physiological taplasia and to a well differentiated, new squa- us epithelium. These changes are considered a rmal transformation zone.

An abnormal response changes into an atypical taplasia under the influence, perhaps, of early ual experience, viral infection or diethylstilbes- l (DES). Therefore, atypical metaplasia under- es two alternate responses. With an adequate st response, there is no progression of the lesion, ich may remain constant and unchanged throughout the patient's life. With an inadequate host response, mild, moderate and severe dysplasia may occur and be followed by cervical in situ carcinoma and, ultimately, by invasive carcinoma. This probably is a progressive disease requiring many months and years to occur. The atypical metaplasia and its progression with an inadequate host response are termed an abnormal transformation zone. The real value of the colposcope lies in the fact that these changes may be identified. It allows us to understand the patho-physiology and permits us to follow the patient continuously in a monitored manner.

COLPOSCOPIC TERMINOLOGY AND DIAGNOSIS

The understanding of the patho-physiology of cervical squamous epithelium has been cleared immensely by the use of the colposcope. It has been estimated that in the past, 45 to 50 terms have been utilized to describe the changes in cervical epithelium.[8] We realize now that this can be limited to a few terms which are meaningful, namely, metaplasia, dysplasia, carcinoma in situ and invasive carcinoma. Other frequently utilized terms are cystic cervicitis, cervicitis, parakeratosis, acanthosis and hyperkeratosis. In addition to the patho-physiologic changes that are pinpointed, clinical experience utilizing the cervical cone is better understood and performed by use of the colposcope.

We have found that in younger patients, the transformation zone tends to be further out on the

COLPOSCOPIC TERMINOLOGY

Normal Colposcopic Findings:
  1. Original Squamous Epithelium
  2. Columnar Epithelium
  3. Transformation Zone

Abnormal Colposcopic Findings:
  1. Atypical Transformation Zone
    a. White epithelium
    b. Punctation
    c. Mosaic
    d. Leukoplakia
    e. Abnormal blood vessels
  2. Suspect Frank Invasive Cancer

Other Colposcopic Findings:
  1. Vaginocervicitis
  2. True Erosion
  3. Atrophic Epithelium
  4. Condyloma, Papilloma

Fig. 2

cervix. Therefore, a wider, more shallow cone is usually indicated. In older patients, the transformation zone extends further up into the endocervical canal so a narrow and longer cone is more advantageous. Therefore, the transformation zone changes with the age of the patient. These transformation borders may be definitely outlined, thus allowing a conization to be done according to the dictates of the colposcope.

The colposcope appearance of the cervix and an abnormal transformation zone exhibits five abnormal changes or patterns: (1) white epithelium, (2) punctation, (3) mosaic, (4) leukoplakia and (5) abnormal blood vessels. These findings are present in varying degrees and all are significant (Fig. 2). Positive findings are caused by three conditions: (1) neoplasia, (2) inflammation and (3) regeneration of tissue. Thus, an abnormal colposcopic finding does not necessarily mean neoplasia.

The use of the colposcope for biopsy renders obsolete the four-quadrant biopsy procedure. A biopsy under direct visualization gives a more accurate and scientific evaluation of the diseased area. A four-quadrant biopsy is a blind procedure that relies on chance to remove the affected area. Another advantage of the colposcope allows us to do a directed biopsy.

Colposcopy will not eliminate conization of the cervix, which remains a useful diagnostic and therapeutic modality, but the necessity of diagnostic conization has been greatly reduced to as much as 90% in the best series (Ortiz and Odell, as cited by Scott[9]). Stafl and Mattingly[6] presented a series of 1,410 patients of whom 1,206 had abnormal pap smears and 204 had grossly suspicious cervical lesions. Diagnostic conization was considered necessary in only 80 patients (5.6%). However, 180 patients (12.8%) were unsatisfactorily evaluated by colposcopy because the squamous columnar junction or transformation zone was not fully visible.

Indications and Value of the Colposcope

Indications for use of the colposcope vary widely. Its use should be considered from two standpoints: (1) in private practice and (2) in a teaching environment. Some physicians use the colposcope routinely on all patients. Others use the colposcope only with abnormal pap smears or prior to treating an abnormal cervix. For example, this gives us a clear-cut method of following a patient with a Class II pap smear. It has been our experience that if patients having Class II or III pap smears are treated with an antibiotic cream or suppository prior to doing colposcopic examinations, the pap smear will occasionally revert to a Class I. If not, the colposcopic findings will pinpoint the abnormal squamous epithelium for directed biopsies.

A general rule is that if there is any doubt about the lesion, a biopsy should be performed. Consequently, the more inexperienced colposcopists will usually do more biopsies than those who are more experienced. The proper diagnosis must be made and the explanation of the abnormal pap smears must be clear and complete.

Technique of Colposcopy

The patient is prepared for a normal vaginal examination. A speculum using a Graves Bivalve open side is utilized. The cervix must be entirely exposed and the upper vagina and cervix bathed with 3% to 4% acetic acid. The acetic acid brings out the vascular patterns as well as the surface changes of the cervix. The bathing of the cervix must be intermittently applied as visualization and study of the cervix are continued. If a positive area is noted and considered an abnormal colposcopic finding, a biopsy may be taken with special biopsy forceps adaptable for use with the colposcope. These specimens are submitted with proper identification and location. This is mandatory. In younger patients, when a colposcopic examination is required, particularly a DES situation, Xylocaine gel can be utilized to eliminate some of the discomfort of the speculum. However, colposcopic examination itself is completely painless since it is a visual examination.

The DES Problem

The Stilbestrol story was first given attention in the United States by Herbst and Scully[10] from arvard University. They noted that female chil- en of women who received Stilbestrol during egnancy had a high incidence of abnormal find- gs in the cervix and vagina. These findings may divided into two categories: benign changes and lignant changes.

The benign changes have been shown to be an plosion of the columnar epithelium at the trans- mation zone that has developed during the em- yologic formation of the vagina and cervix. In ny instances, instead of being limited to the rvix, the transformation zone has been literally iven down into the upper third of the vagina. In se cases, the transformation zone has become dened. Consequently, when metaplasia occurs, ands of glands and columnar epithelium will be en far out on the cervix and in the upper third the vagina. This is termed *adenosis*. The adenosis adually undergoes metaplastic change, conform- g to the sequence of events and change referred earlier (Fig. 1).

Other benign changes of the cervix include de- lopment of a hood which is a rim of columnar ithelium tissue extending around a portion of the per vagina. Many times this hood gives the im- ession of a small myoma protruding through the rvical os. The myoma-like area is really the cervix vered by columnar epithelium. Patients have en unnecessarily subjected to excision of this ea. This change requires no treatment. Another nign change that is found in the DES cases is a ckscomb or a peaked area in the upper third of e vagina anterior to the cervix. This area is usual- covered by columnar epithelium.

The latest approach to following a DES benign ange has been frequent observation in addition encouraging a low Ph or acid vaginal environ- ent.[11] The use of acid gel and vinegar douches or y other acid-producing cream will hasten the nsformation of columnar epithelium to new uamous epithelium.

Benign changes resulting from DES, then, in- lve widening of the transformation zone with lumnar epithelium dispersed throughout the up- r third of the vagina and over the entire cervix. rough a process of metaplasia, this change will ontaneously correct itself and create new squa- ous epithelium. This brings up an interesting int. In later years, increased numbers of squa- ous cell carcinoma of the upper vagina and fur- er out on the cervix might be anticipated as a sult of this widening.

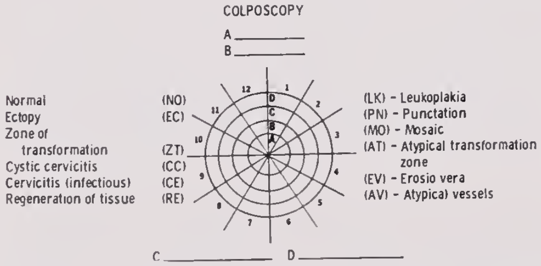
The colposcope is quite useful in following pa- ents with a DES history. The malignant change of the DES problem is usually a clear cell adenocarcinoma. Herbst and Scully[10] have described the phenomenon in detail. To date, there have been no known cases of benign DES changes that have subsequently converted to malignancies, but there have been patients with adenosis and clear cell adenocarcinoma existing simultaneously. The total number of malignancies encountered with a DES history compared with the use of Stilbestrol in several millions of patients is quite small, however. There have been between 200 to 300 known cases of clear cell adenocarcinoma in the United States reported up to January 1975.[11, 12]

Herbst and Scully[11] have a registry for DES patients, particularly the malignant variety, and all patient names and information should be forwarded in detail to these physicians for use in this registry.

Discussion

It is obvious to those who are using the colposcope that the procedure has become not only useful but mandatory for examining the cervical epithelium and, more particularly, the transformation zone. An adjunct to the pap smear, it should be utilized prior to any definitive therapy. It allows for more proper conizations, eliminates the four-quadrant biopsy, thus permitting directed biopsies, and provides a method for following abnormal pap smears or other abnormal findings. It has allowed us to eliminate many unnecessary conizations and, perhaps, complications resulting from these procedures. It is particularly valuable in studying the cervix of a pregnant patient who has an abnormal pap smear. The use and value of the colposcope in postradiation patients have been very limited.

Colposcopy is a simple procedure that may be mastered after several examinations of the cervix. Colposcopy should be utilized in every locality and every hospital should have a hospital-based colposcopist. It in no way impinges upon the use of the pap smear but, rather, supplements it. In addition,



Rubber Stamp—May Be Used on Progress Sheet or Tissue Request—Technique Used for Colposcopist and Pathologist Communication.
Scott, J. W.: Stereocolposcopic Atlas of the Uterine Cervix. Kendall, Fla., 1971, p. 108. Zephyr Pub.

Fig. 3

a very close working relationship with the pathologists is mandatory. The biopsies obtained on colposcopic examinations are smaller, requiring more technical understanding between the colposcopist and the pathologist (Fig. 3). The colposcopist should review the slides with the pathologist, utilizing the standard communication. The pathologist should take time to view colposcopic lesions. It is *very* important that the nurses assisting in colposcopy be instructed fully about the care of the colposcope and related instruments. Furthermore, patients should be properly instructed concerning colposcopy so that their cooperation is attained. We have accomplished this through brochures that the patient reads prior to examination. These pamphlets are available not only for routine colposcopy but for explanation of the DES story, its terminology and problems.

Although we did not discuss the treatment of an abnormal transformation zone, it is usually undertaken by three modalities: (1) excision in the form of conization, (2) electro-cautery and (3) a more newly utilized procedure, cryosurgery. It should be noted, however, that once these procedures have been undertaken, they often destroy the normal transformation zone. Therefore, once therapy is instituted, the value of the colposcope diminishes in follow-up examinations.

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Opinion & Dialogue

Should a specially prepared package insert be made available to patients?

Dr. Alexander M. Schmidt
Commissioner,
Food and Drug
Administration

The idea of a so-called pat package insert has been arounc a long time. Many physicians alr use written instruction sheets tc provide patients with informatio about the drugs they are taking. some physicians give verbal inst tions; but in too many instances these are what I call eye-glazing ercises. I have seen patients sit glazed eyes listening to a rapid-f lecture by a hurried physician wl has 20 people out in his waiting room. These patients aren't give sufficient understanding and the fore do not follow instructions. S think the idea of an official packa insert for patients is a good one. Perhaps we should really think o this kind of information simply a extension of drug labeling.

The benefits of patient involveme

Many physicians may not re ize how frequently a patient obta his drug information from Aunt Tillie or the next door neighbor. A this information is almost alway bad or irrelevant to the case at ha Furthermore, the incentive to go along with a prescribed program slim if the only reading matter the patient receives, along with his pr scription, is a bill.

As an educator I am impress by the principle that the best way get someone to do something is to involve him in the process. So the

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Dr. James H. Sammons
Executive Vice President
of the American
Medical Association

I think there are advantages well as some real disadvantages in a patient package insert. When you begin to use semi-medical or medical terms to describe complicatio or possible sequelae of disease or treatment, you may frighten the patient—particularly since the more highly sophisticated patient is not the one who is going to read the insert. The patient who will read it is the one most susceptible to fright and confusion by the language.

On the positive side, a packag insert will probably give the patient better insight into why he is being treated the way he is, and it may give the physician a little bit more time. But it does not remove from the physician the need or obligatio to explain the insert.

Some pitfalls in the inclusion of side effects

Certainly a patient should be warned of the possibility of serious side reactions—to know what the real dangers are. But it doesn't do a bit of good to indicate that a patient on oral penicillin may develop a rash, itching, or a drop in blood pressure. Or that he may faint. I think the real danger is that fright engendered by the insert may possibly outweigh the potential good.

main purpose of drug information for the patient is to get his cooperation in following a drug regimen.

Preparation and distribution of patient drug information

We would hope to amass information from physicians, medical societies, the pharmaceutical industry and centers of medical learning. The ultimate responsibility for uniform labeling must, however, rest with the Food and Drug Administration. There is nothing wrong with this agency saying, "this information is generally agreed upon and therefore it should be used," as long as our process for getting the information is sound.

Distribution of the information is a problem. In great measure it would depend on the medication in question. For example, in the case of an injectable long-acting progesterone, we would think it mandatory to issue two separate leaflets—a short one for the patient to read before getting the first shot and a long one to take home in order to make a decision about continuing therapy. In this case, the information might be put directly on the package and not removable at all. But for a medication like an antihistamine this information might be issued separately, thus giving the physician the option of distribution. This could preserve the placebo use, etc.

It is in the distribution of patient information that the pharmacist may get involved. As professionals and members of the health-care team and as a most important source of drug information to patients, pharmacists should be responsible for keeping medical and drug records on patients. It is also logical that they should distribute drug information to them.

Realistic problems must be considered

We have to expect that the introduction of an information device will also create new problems. First, how can we communicate complex and sophisticated information to people of widely divergent socioeconomic and ethnic groups? Second, what will we say? And third, how can we counteract the negative attitude of many physicians toward any outside influence or input? Hopefully the medical profession will respond by anticipating the problems and helping to solve them. Assuming we can also solve the difficulty of communicating information to diverse groups throughout the United States, our remaining task will be the inclusion of appropriate material.

What information is appropriate?

In my opinion, technical, chemical and such types of material should not be included. And there is no point in the routine listing of side effects like nausea and vomiting which seem to apply to practically all drugs, unless it is common with the drug. However, serious side effects should be listed, as should information about a medication that is potentially risky for other reasons.

Other pertinent information might consist of drug interactions, the need for laboratory follow-up, and special storage requirements. What we want to include is information that will help increase patient compliance with the therapy.

Positive aspects of patient drug information

Labeling medication for the patient would accomplish a number of good things: the patient could be on the lookout for possible serious side effects; his compliance would increase through greater understanding; the physician would be a better source of information since he would be freer to use his time more effectively; other members of the health-care team would benefit through patient understanding and cooperation; and, finally, the physician-patient relationship would probably be enhanced by the greater understanding on the part of the patient of what the physician is doing for him.

Only the doctor can remove that fear by 20 or 30 minutes of conversation.

I'm not suggesting that we withhold any information from the patient because, first of all, it would be totally dishonest and secondly, it would defeat the very purpose of the insert. I do think that a patient on the birth control pill should know about the incidence of phlebothrombosis.

If you're going to tell a patient the incidence of serious adverse reactions, then you have to tell him that a concerned medical decision was made to use a particular medication in his situation after careful consideration of the incidence of complications or side effects.

Emotionally unstable patients pose a special problem

There are patients who, because of severe emotional problems, could not handle the information contained in a patient package insert. Yet if we are going to have a package insert at all, we just can't have two inserts. I think we might simply have to tell the families of these patients to remove the insert from the package.

Legal implications of the patient package insert

Just what effect would a patient package insert have on malpractice? We could try to avoid any legal implications by pointing out that the physician has selected a particular medication because, in his professional judgment, it is the treatment of choice. For instance, you can't tell everyone taking antihistamines not to work just because a few patients develop extreme drowsiness which can lead to accidents. And what about the very small incidence of aplastic anemia rarely associated with chloramphenicol? If, based on sensitivity studies and other criteria, we decide to employ this particular antibiotic, we do so in full knowledge of this serious potential side effect. It's not a simple problem.

How do we handle an insert for medication used for a placebo effect?

With rare exceptions, physicians no longer use medications for a placebo effect. This question does raise the issue of how a patient may react to receiving a medication without a package insert.

Preparation of the package insert

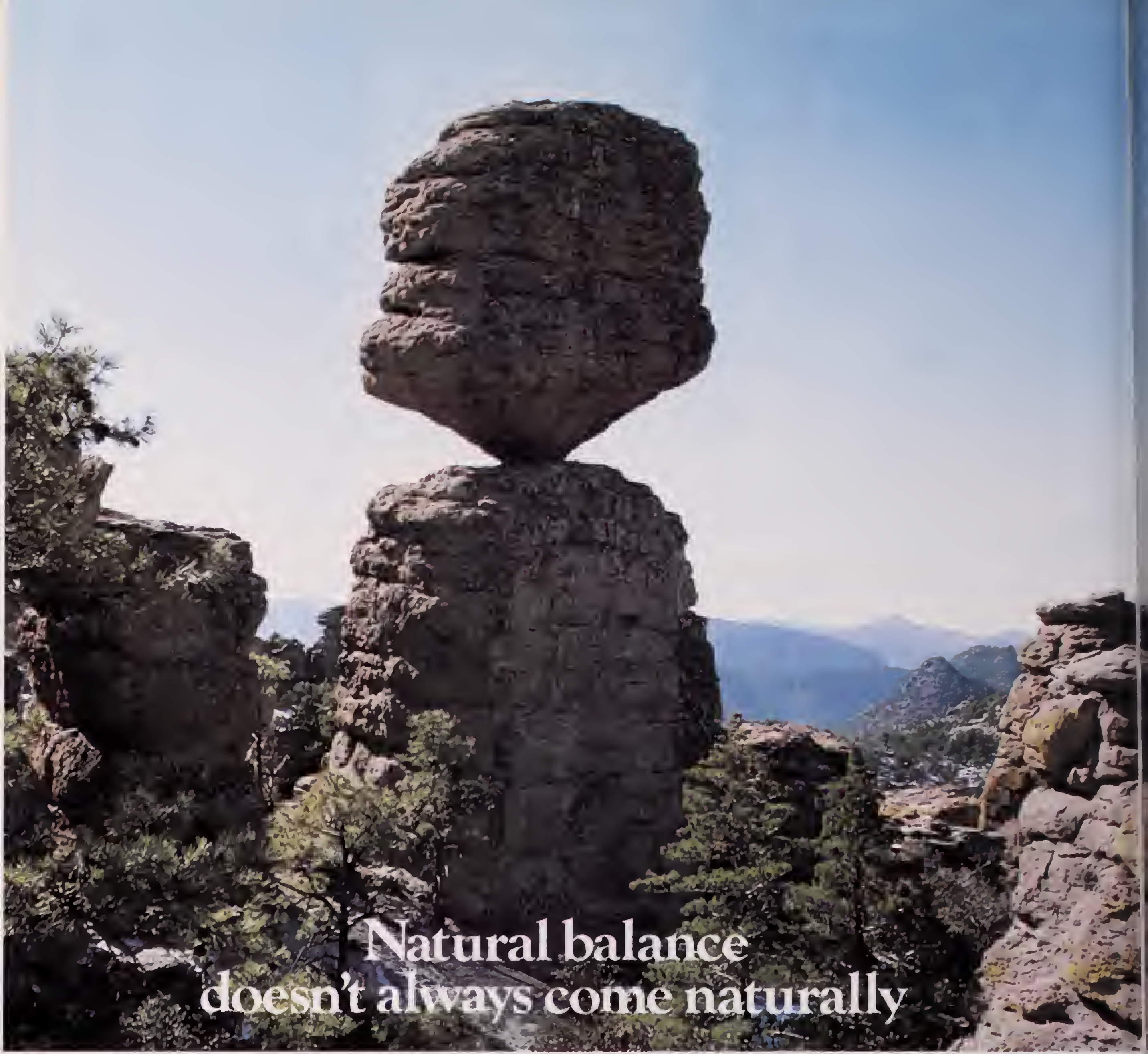
The development of the insert ought to be a joint operation between physicians, the pharmaceutical industry, the A.M.A. and the F.D.A.

I view the A.M.A.'s role as a coordinator or catalyst. It is the only organization through which the profession as a whole, irrespective of specialty, can speak. It has relatively instant access to all the medical expertise in this country. And it can bring that professional expertise together to ensure a better package insert. The A.M.A. can work in conjunction with the industry that has produced the product and which is ultimately going to supply the insert.

I don't think we should rely, or expect to rely, on legislative committees and their nonprofessional staffs to make these decisions when it is perfectly within the power of the two groups to resolve the issues in the very best American tradition—without the government forcing us to do it. I think the F.D.A. has to be involved, but I'd like them to become involved because they were asked to become involved.

Pharmaceutical
Manufacturers Association
1155 Fifteenth Street, N.W.
Washington, D.C. 20005

P·M·A



Big Balanced Rock, Chiricahua Mountains, Arizona (approx 1,000 tons)

☐ Found useful in the management of vertigo* associated with diseases affecting the vestibular system.
☐ Can relieve nausea and vomiting often associated with vertigo.*
☐ Usual adult dosage for Antivert/25 for vertigo:* one tablet t.i.d.
☐ Also available as Antivert (meclizine HCl) 12.5 mg. scored tablets, for dosage convenience and flexibility.
☐ Antivert/25 (meclizine HCl) 25 mg. *Chewable* Tablets for nausea, vomiting and dizziness associated with motion sickness.

BRIEF SUMMARY OF PRESCRIBING INFORMATION

*INDICATIONS. Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

Effective: Management of nausea and vomiting and dizziness associated with motion sickness.

Possibly Effective: Management of vertigo associated with diseases affecting the vestibular system.

Final classification of the less than effective indications requires further investigation.

CONTRAINDICATIONS. Administration of Antivert (meclizine HCl) during p
nancy or to women who may become pregnant is contraindicated in view of
teratogenic effect of the drug in rats.

The administration of meclizine to pregnant rats during the 12-15 day of gesta
has produced cleft palate in the offspring. Limited studies using doses of over 100 n
kg./day in rabbits and 10 mg./kg./day in pigs and monkeys did not show cleft pal
Congeners of meclizine have caused cleft palate in species other than the rat.

Meclizine HCl is contraindicated in individuals who have shown a previous hy
sensitivity to it.

WARNINGS. Since drowsiness may, on occasion, occur with use of this drug, pati
should be warned of this possibility and cautioned against driving a car or operat
dangerous machinery.

Usage in Children: Clinical studies establishing safety and effectiveness in child
have not been done; therefore, usage is not recommended in the pediatric age group

Usage in Pregnancy: See "Contraindications."

ADVERSE REACTIONS. Drowsiness, dry mouth and, on rare occasions, blur
vision have been reported.

More detailed professional information available on request.

ROERIG Pfiz
A division of Pfizer Pharmaceutic
New York, New York 10017

Antivert®/25
(meclizine HCl) 25 mg. Tablets
for vertigo*

creening Asymptomatic Women

Continued from page 695)

hysician. In the other two cases, the physicians ave elected to defer biopsy.

In summary, only two biopsies out of the 198 ıses have not been done because of unwillingness ı the part of the physician to accept the project's port as the sole indication for establishing a tis- ue diagnosis.

ANCER CASES

Thirty biopsies diagnosed as "cancer" have been ported for an instance of six per 1,000 or 15% of e total biopsies recommended. Three clinical can- ers were identified that showed no mammographic idence of their presence as indicated in the mam- ography section. While thermographic abnormali- es alone are insufficient to proceed with biopsy, e method does provide strong corroborative sup- ort when debating a biopsy decision. All of this dicates that the highest degree of accuracy in e diagnosis of minimal breast cancer and its subsequent treatment is best accomplished when the combination of the three methods is utilized and when close cooperation is present among the clinician, the radiologist and the thermographer. Beyond this, close cooperation is necessary among the project, the physician who carries out the surgery, the local hospital pathologist and the radiologist.

Refinement in the diagnosis of breast cancer requires refinements in surgical, radiologic, thermographic and pathology procedures. It does, indeed, demand unusual time and effort. Those dissatisfied with our previous accomplishments in the diagnosis and treatment of breast cancer will be willing to make the effort. It could prove worthwhile.

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1. Rodes, N. D., Blackwell, C. W. and Farrell, C.: Missouri Breast Cancer Demonstration Project. Mo. Med. 71:685, 1974.
2. Byrne, R. and Yerex, J. A.: The Three Roles of Breast Thermography. Appl. Radiol., p. 53, May/June 1975.
3. Donegan, W. L.: Mastectomy in the Primary Management of Invasive Mammary Carcinoma. In Hardy, J. D. (Ed.), Advances in Surgery, Vol. 6. Chicago, Year Book Medical Pub., 1972, 101 pp.

Continuing Education Coming Events

Jan. 12	**City-Wide Radiology Conference: New Techniques in Pediatric Radiology** Mallinckrodt Institute of Radiology Washington U. School of Medicine, St. Louis
Jan. 22	**Second Annual Perinatal Symposium** St. Louis U. Medical Center Continuing Education Sesquicentennial Room, Busch Memorial Center, St. Louis
Feb. 2-3	**Symposium: Recent Advances in the Treatment of Neurological Diseases** Division of Continuing Medical Education K.U. Medical Center, Kansas City, Kan.
Feb. 5-6	**Topics in Pulmonary Medicine** Continuing Medical Education Washington University School of Medicine, St. Louis
Feb. 20-21	**The Long Weekend—Clinical Cardiology and Physical Examination of the Heart** MU-KC School of Medicine Crown Center Hotel, Kansas City
March 1-2	**Symposium: Emergency Medicine—The First 40 Minutes** Division of Continuing Medical Education K.U. Medical Center, Kansas City, Kan.

Send Your Gift Today!

MISSOURI STATE MEDICAL FOUNDATION
113 Madison
Jefferson City, Missouri 65101

Dear Doctor:

"Missouri physicians encouraging and helping Missouri young people to attend medical school."

The above vital words state the purpose and goal of the Missouri State Medical Foundation, which has provided more than 1,288 loans to Missouri medical students since 1960.

The money for these loans has been made available through the generosity and dedication of the practicing physicians of Missouri.

Despite this past and present generosity, however, additional money is still needed to provide all the loans we would like to make to assist students.

You, as a practicing physician in Missouri, can make more funds available by contributing to the Foundation now. Such donations are tax deductible. This is an excellent time to make your 1975 gift since we are near the close of the tax year.

The need for more physicians is still great. We of the Missouri State Medical Association can and must help to fill this need by providing loans to medical students who are residents of our state. I am certain that you would not want the Foundation to turn away any deserving student because of our lack of funds.

Please send your check now. Make it payable to the Missouri State Medical Foundation and mail it to Box 1028, Jefferson City 65101. Today is not too soon.

Sincerely yours,

Albert D. Cross, M.D.

President

SPONSORED BY THE MISSOURI STATE MEDICAL ASSOCIATION

The Missouri State Medical Foundation is classified by the Internal Revenue Service under Section 509(a)(3). Individuals may deduct up to 50% of their adjusted gross income for contributions made to the MSMF.

President's Message

WE NEED YOUR HELP

Judging from several meetings with doctors from around the state, it is obvious that many MSMA members are not reading the information on the malpractice insurance situation which has been furnished to them.

Each member has received two mailings dealing with the malpractice situation, and the yellow News Report pages of this Journal have published detailed articles monthly on the legislative bills proposed by the Missouri Senate Select Committee on Malpractice and the Governor's Advisory Committee on Malpractice.

I have been asked, "What is the MSMA doing about the malpractice crisis?"

The answer is that the MSMA is doing what it has been doing since 1969 . . . only more so. Your Association has battled attempts to lengthen the Statute of Limitations during the last six or seven years, and we have been successful. We have worked to improve the medical practice act through adoption of the "Sick Doctor" Statute. Again, we were successful.

The MSMA has been deeply involved in drawing up the language in the proposed remedial legislation which will be introduced in the coming General Assembly. Again, our input has been great!

Therefore, when members ask how they can help the Association gain approval of the proposed bills, I say we have not veered from our original "Key Man" concept which has proved so successful. This concept can be even more productive with your help.

R. Allen Chandler, M.D.

We need to bolster our "Key Man" list with the names of those MSMA members who are personal physicians of state legislators or are good friends of their legislators. Please send this information to the Legislative Committee, MSMA, P.O. Box 1028, Jefferson City, Mo. 65101. In turn, you will receive information on the bills and an explanation of what to do and what not to do. This project will require the time of and work by many, many members.

I want to assure all MSMA members that they will be kept informed on the progress and details of malpractice legislation as it is introduced and proceeds through the legislature. However, it is impossible to keep you informed if you fail to read the material which is furnished. Remind your colleagues to keep abreast!

We must work together to attain the legislative goals we are seeking. We shall combine the highly successful concepts of the past with the added strength of greater "Key Man" participation. If the entire MSMA will unite and express knowledgeable concern about the malpractice insurance crisis to their legislators, we CAN pass proper legislation to help correct the situation!

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- *Eastern Missouri Administrator*

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Woman's Auxiliary

My guest columnist this month is Mrs. Donald (Ina May) Fakhoury who suggests **the best way to insure that Missouri medical schools will get the benefit of your dollar donations.** She is the Auxiliary's State AMA-ERF chairman and the wife of a Clay County family practitioner.

Warmly,

Mary Kay McPhee

Mrs. William R. McPhee
President

Beginning this year, the AMA-ERF Awards made by the National Auxiliary will be based only on contributions which are made directly through the Auxiliary. To be sure that your county auxiliary and the MSMA Auxiliary receive credit for your donation, please send your check to your county AMA-ERF chairman. If your county does not have an organized auxiliary, you are urged to send your contribution directly to the state chairman at the following address:

Mrs. Donald Fakhoury
4332 N. Central
Kansas City, Mo. 64116

The county auxiliaries are busy with many different projects to raise money for the AMA-ERF. In the past 24 years, more than $25 million have been contributed by members and friends to meet the needs of medical schools, students, interns and residents. Your encouragement via contributions through your own local and state auxiliaries will help to win recognition for the efforts of our hard-working members in Missouri.

So, please don't forget. When that letter requesting AMA-ERF donations comes to you, DO CONTRIBUTE and make your contribution count for Missouri by channeling it through the Auxiliary.

Thank you,
Ina May Fakhoury
AMA-ERF Chairman

County Society News

FIRST DISTRICT

COUNCILOR
JOHN N. MARTIN, M.D., ST. JOSEPH

Buchanan County Medical Society

For the 20th consecutive year, members of the Buchanan County Medical Society and the St. Joseph Bar Association met jointly. The occasion was a dinner and program at the Moila Club in St. Joseph on November 5. Eighty-six physicians and attorneys attended the event.

Presiding jointly were the two organizations' presidents, Dr. William B. O'Connor and Joseph K. Houts.

The program was a discussion of "The Missouri Traffic Law Systems Plan" by Mr. Robert E. Burgess, coordinator of Traffic Law Systems for the Missouri State Highway Department. He advised that Missouri's Traffic Systems Plan is working very well due to support from the legal and medical professions and the public. He said that future improvement in the Missouri traffic program is contingent upon continued support from the professions and the public.

The program was arranged by Richard Trippler, manager of the St. Joseph Safety Council, who also introduced the speaker.

Carl K. Ness, M.D., *Secretary*

Clay County Medical Society

William R. McPhee, M.D., North Kansas City, was elected President-Elect of the Clay County Medical Society at its November meeting.

Dr. McPhee will succeed Dr. Donald A. Fakhoury who will assume the Presidency of the Society on Jan. 1, 1976. The current President is Richard C. Hedges.

Other officers elected at the meeting are William D. Soper, Vice-President and Dr. Jerry Cook, Secretary-Treasurer.

Dr. Thomas H. Hendren was elected to a thr year term on the Board of Censors. Drs. C. Stratman, Newton McCluggage and J. J. Und wood III were elected to the Executive Committ

Elected as Delegates to the MSMA were D Fakhoury, Donald E. Kuenzi, Truman B. Sche and Richard C. Hedges.

Isle
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TENTH DISTRICT

COUNCILOR
EUGENE T. HANSBROUGH, M.D.,
POPLAR BLUFF

Mineral Area Medical Society

Members of the Mineral Area Medical Socie held a dinner meeting at the Bridlewood Count Club in Farmington on October 1.

The business meeting was conducted by t President, Dr. Norma Farmer. The Credenti Committee's recommendation that the applicati of Dr. Simpalo of Potosi be approved was accept unanimously by the membership.

Dr. C. W. Chastain announced that a meeti for county medical society officers will be held October 18-19 at the Lake of the Ozarks. He mov that the membership approve payment of one ha of the expenses for as many as two physicians a their wives from Farmington who attend the mee ing. His motion was seconded by Dr. R. A. Huc step and approved.

A motion to endorse Bollinger County's applic tion to obtain a physician through the Nation Medical Service Corp. was approved.

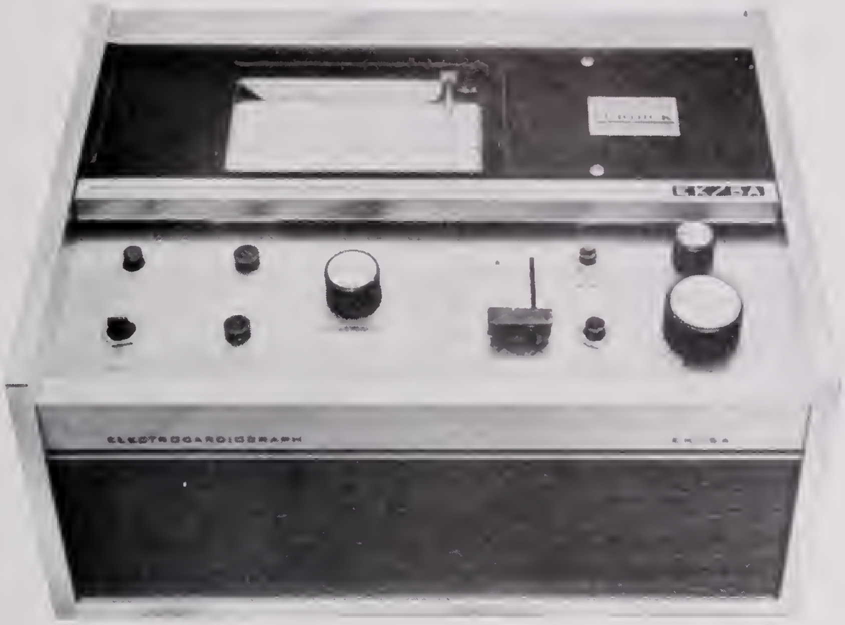
Dr. Chastain moved that the Society's dues f 1976 be $10. The motion was seconded by Dr. Ja F. Tuttle and carried.

In other business, Alvan G. Karraker reported o the present situation in the Southeast Missou Medical Foundation and Dr. Huckstep reported o the recent hearing by a select committee of th Missouri State Senate on proposed changes in ma practice insurance and regulations.

There being no further business, the meeting w adjourned.

C. W. Chastain, M.D., *Secretar*

WHEN YOU BUY THIS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Notes of interest from Here .... and There

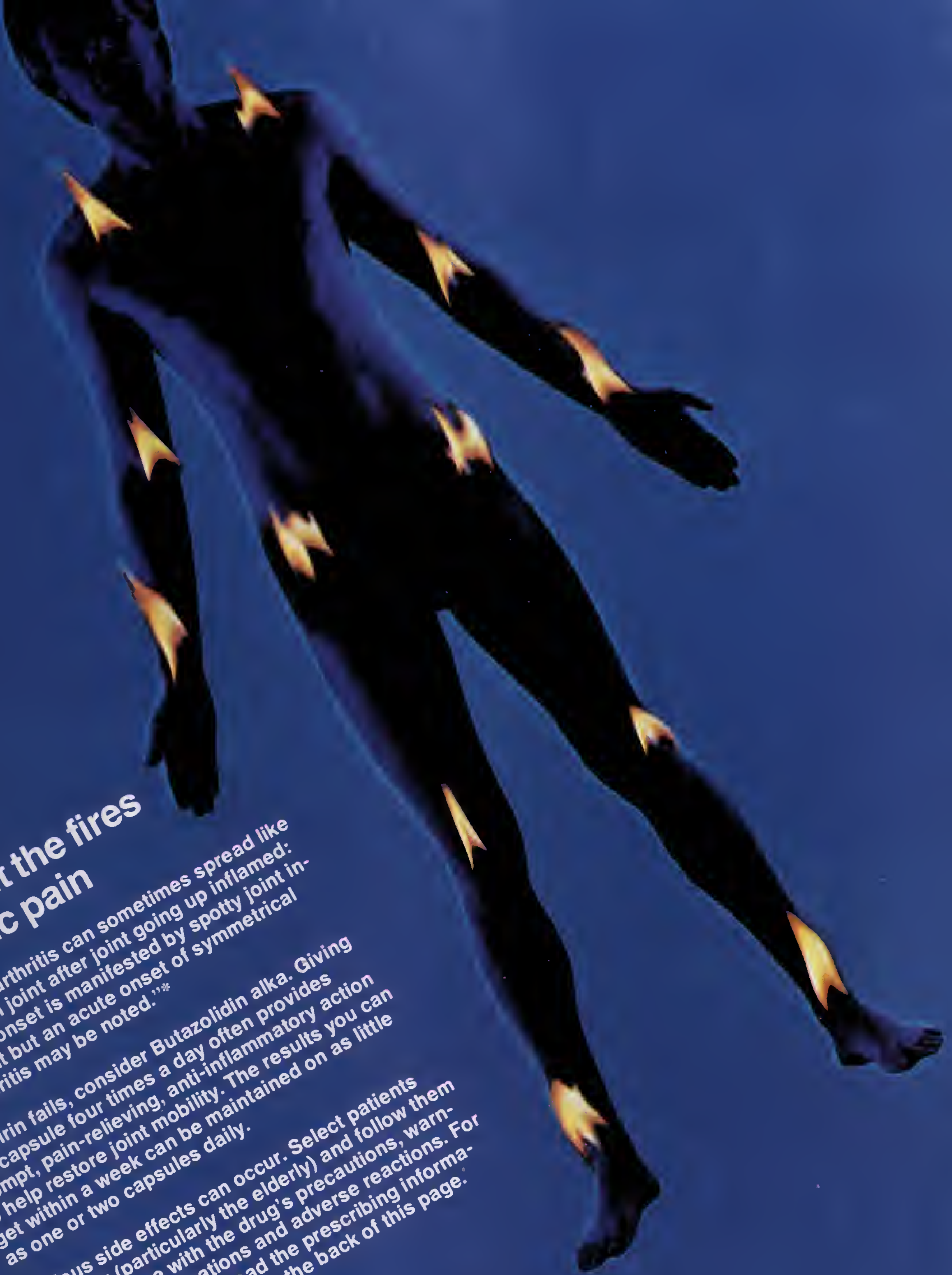
Dr. Frederick J. McCoy, Kansas City, has been named president of the American Society of Plastic and Reconstructive Surgeons. Dr. McCoy, who is chief of plastic surgery at the General Hospital and a staff member of other hospitals, has practiced in Kansas City since 1950.

Dr. Charles A. Worley, Sweet Springs, was installed as president of the Missouri Academy of Family Physicians (MAFP) on November 8 at the 27th Annual MAFP Scientific Assembly held at the Lodge of the Four Seasons, Lake of the Ozarks. Other officers installed by past-president **Lois Wyatt** of St. Louis were **Dr. Max Haight**, Kansas City, president-elect; **Dr. David W. Hall**, Springfield, vice-president; and **Dr. George P. Williams**, Grandview, secretary-treasurer. **Drs. Irving H. Clark**, Kansas City; **Paul T. Berry**, Springfield; and **Otey S. Jones**, St. Louis, were installed as board members. Dr. Worley is a diplomate of the American Board of Family Physicians and a charter fellow of the American Academy of Family Physicians. He is a member of the MSMA Commission on Continuing Education and chairman of the Ad Hoc Health Manpower Committee.

Dr. Raymond A. Ritter has received an honorary membership in the Friends of St. Francis Medical Center at that organization's first banquet in Cape Girardeau on November 12. **Mr. Fred R. Wilferth**, president, bestowed the honor and referred to Dr. Ritter as "an outstanding leader in the health care field." Dr. Ritter is chief-of-staff at St. Francis Hospital and a past-president of the Cape Girardeau County Medical Society. He also has served as Vice-President of the MSMA and as a member of the Board of Registration for the Healing Arts.

Dr. Edmond Guldner is the recipient of the first annual "Man of the Year" Award for "outstanding and dedicated service" to be presented by the Chamber of Commerce of Lamar. Dr. Guldner, who was born in Thionville, France in 1890. He entered the Strasburg Medical School at the age of 18. The famed Dr. Albert Schweitzer, 18 years his senior, was a member of his graduating class. He also studied in Freiburg, Germany and Vienna, Austria. Dr. Guldner began his practice in Lamar in 1944. Among other honors, he is the recipient of "The Academic Palms," the highest medal of medicine awarded in France. Also, the French government has bestowed upon him the Chevalier of the Public Health Order. His medical career has spanned 61 years.

Dr. Jack S. Sanders is one of six area business and professional persons to be elected to the Board of Directors of the Jefferson City Area Chamber of Commerce.—**Dr. Francis Tarvydas** of Edina was presented a certificate of appreciation on November 12 for his service to the Red Cross Bloodmobile Drive in Knox County. He has worked with the Bloodmobile for more than 20 years.



Putting out the fires of arthritic pain

Rheumatoid arthritis can sometimes spread like wildfire, with joint after joint going up inflamed: "The usual onset is manifested by spotty joint involvement but an acute onset of symmetrical polyarthritis may be noted."*

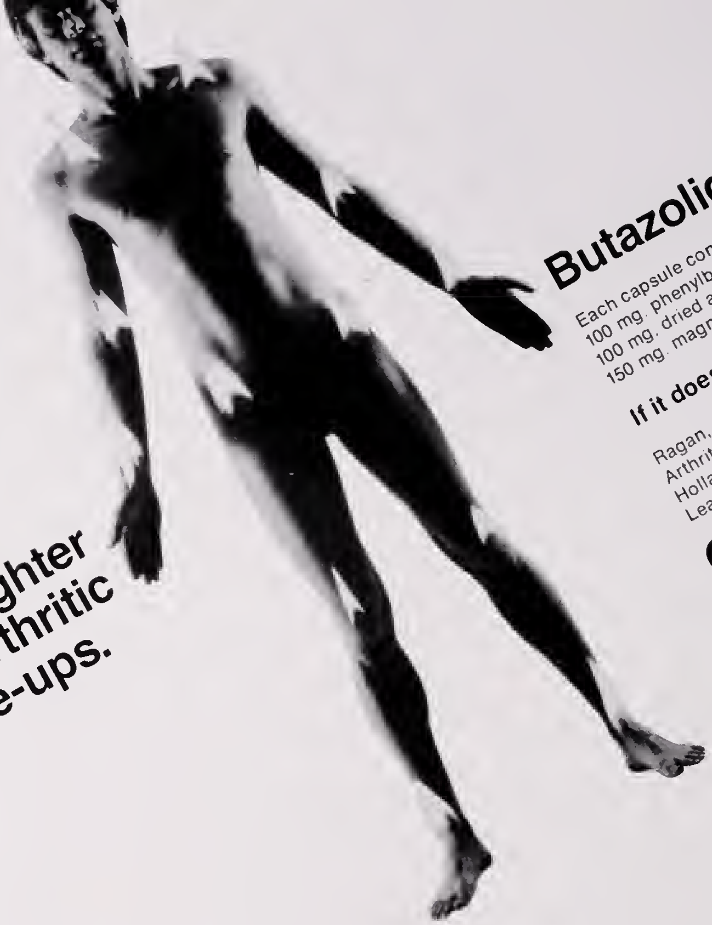
If aspirin fails, consider Butazolidin alka. Giving one capsule four times a day often provides prompt, pain-relieving, anti-inflammatory action to help restore joint mobility. The results you can get within a week can be maintained on as little as one or two capsules daily.

Serious side effects can occur. Select patients carefully (particularly the elderly) and follow them closely in line with the drug's precautions, warnings, contraindications and adverse reactions. For full details, please read the prescribing information. It's summarized on the back of this page.

Butazolidin® alka

Each capsule contains:
100 mg. phenylbutazone USP
100 mg. dried aluminum hydroxide gel USP
150 mg. magnesium trisilicate USP

If it doesn't work in a week, forget it.



Fire fighter for arthritic flare-ups.

Butazolidin® alka

Each capsule contains:
100 mg. phenylbutazone USP
100 mg. dried aluminum hydroxide gel USP
150 mg. magnesium trisilicate USP

If it doesn't work in a week, forget it.

Ragan, C.: The Clinical Picture of Rheumatoid Arthritis, in Arthritis, ed. 8, edited by J. L. Hollander and D. J. McCarty, Jr., Philadelphia, Lea & Febiger, 1972, chap. 21, p. 335.

Geigy

Important Note: This drug is not a simple analgesic. Do not administer casually. Carefully evaluate patients before starting treatment and keep them under close supervision. Obtain a detailed history, and complete physical and laboratory examination (complete hemogram, urinalysis, etc.) before prescribing and at frequent intervals thereafter. Carefully select patients, avoiding those responsive to routine measures, contraindicated patients or those who cannot be observed frequently. Warn patients not to exceed recommended dosage. Short-term relief of severe symptoms with the smallest possible dosage is the goal of therapy. Dosage should be taken with meals or a full glass of milk. Substitute alka capsules for tablets if dyspeptic symptoms occur. Patients should discontinue the drug and report immediately any sign of fever, sore throat, oral lesions (symptoms of blood dyscrasia); dyspepsia, epigastric pain, symptoms of anemia, black or tarry stools or other evidence of intestinal ulceration or hemorrhage, skin reactions, significant weight gain or edema. A one-week trial period is adequate. Discontinue in the absence of a favorable response. Restrict treatment periods to one week in patients over sixty.

Indications: Rheumatoid arthritis, osteoarthritis, bursitis, acute gouty arthritis and rheumatoid spondylitis.

Contraindications: Children 14 years or less, senile patients; history or symptoms of G.I. inflammation or ulceration including severe, recurrent or persistent dyspepsia, history or presence of drug allergy; blood dyscrasias; renal, hepatic or cardiac dysfunction; hypertension; thyroid disease; systemic edema, stomatitis and salivary gland enlargement due to the drug; polymyalgia rheumatica and temporal arteritis, patients receiving other potent chemotherapeutic agents, or long-term anticoagulant therapy.

Warnings: Age, weight, dosage, duration of therapy, existance of concomitant diseases, and concurrent potent chemotherapy affect incidence of toxic reactions. Carefully instruct and observe the individual patient, especially the aging (forty years and over) who have increased susceptibility to the toxicity of the drug. Use lowest effective dosage. Weigh initially unpredictable benefits against potential risk of severe, even fatal, reactions. The disease condition itself is unaltered by the drug. Use with caution in first trimester of pregnancy and in nursing mothers. Drug may appear in cord blood and breast milk. Serious, even fatal, blood dyscrasias, including aplastic anemia, may occur suddenly despite regular hemograms, and may become manifest days or weeks after cessation of drug. Any significant change in total white count, relative decrease in granulocytes, appearance of immature forms, or fall in hematocrit should signal immediate cessation of therapy and complete hematologic investigation. Unexplained bleeding involving CNS, adrenals, and G.I. tract has occurred. The drug may potentiate action of insulin, sulfonylurea, and sulfonamide-type agents. Carefully observe patients taking these agents. Nontoxic and toxic goiters and myxedema have been reported (the drug reduces iodine uptake by the thyroid). Blurred vision can be a significant toxic symptom worthy of a complete ophthalmological examination. Swelling of ankles or face in patients under sixty may be prevented by reducing dosage. If edema occurs in patients over sixty, discontinue drug.

Precautions: The following should be accomplished at regular intervals. Careful detailed history for disease being treated and detection of earliest signs of adverse reactions, complete physical examination including check of patient's weight, complete weekly (especially for the aging) or an every two week blood check, pertinent laboratory studies. Caution patients about participating in activity requiring alertness and coordination, as driving a car, etc. Cases of leukemia have been reported in patients with a history of short- and long-term therapy. The majority of these patients were over forty. Remember that arthritic-type pains can be the presenting symptom of leukemia.

Adverse Reactions: This is a potent drug, its misuse can lead to serious results. Review detailed information before beginning therapy. Ulcerative esophagitis, acute and reactivated gastric and duodenal ulcer with perforation and hemorrhage, ulceration and perforation of large bowel, occult G.I. bleeding with anemia, gastritis, epigastric pain, hematemesis, dyspepsia, nausea, vomiting and diarrhea, abdominal distention, agranulocytosis, aplastic anemia, hemolytic anemia, anemia due to blood loss including occult G.I. bleeding, thrombocytopenia, pancytopenia, leukemia, leukopenia, bone marrow depression, sodium and chloride retention, water retention and edema, plasma dilution, respiratory alkalosis, metabolic acidosis, fatal and nonfatal hepatitis (cholestasis may or may not be prominent), petechiae, purpura without thrombocytopenia, toxic pruritus, erythema nodosum, erythema multiforme, Stevens-Johnson syndrome, Lyell's syndrome (toxic necrotizing epidermolysis), exfoliative dermatitis, serum sickness, hypersensitivity angiitis (polyarteritis), anaphylactic shock, urticaria, arthralgia, fever, rashes (all allergic reactions require prompt and permanent withdrawal of the drug), proteinuria, hematuria, oliguria, anuria, renal failure with azotemia, glomerulonephritis, acute tubular necrosis, nephrotic syndrome, bilateral renal cortical necrosis, renal stones, ureteral obstruction with uric acid crystals due to uricosuric action of drug, impaired renal function, cardiac decompensation, hypertension, pericarditis, diffuse interstitial myocarditis with muscle necrosis, perivascular granulomata, aggravation of temporal arteritis in patients with polymyalgia rheumatica, optic neuritis, blurred vision, retinal hemorrhage, toxic amblyopia, retinal detachment, hearing loss, hyperglycemia, thyroid hyperplasia, toxic goiter, association of hyperthyroidism and hypothyroidism (causal relationship not established), agitation, confusional states, lethargy; CNS reactions associated with overdosage, including convulsions, euphoria, psychosis, depression, headaches, hallucinations, giddiness, vertigo, coma, hyperventilation, insomnia, ulcerative stomatitis, salivary gland enlargement.
(B)98-146-070-J (10/71)

For complete details, including dosage, please see full prescribing information.

GEIGY Pharmaceuticals
Division of CIBA-GEIGY Corporation
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TRIAMTERENE CONSERVES POTASSIUM WHILE HYDROCHLOROTHIAZIDE LOWERS BLOOD PRESSURE

FOR LONG-TERM CONTROL OF HYPERTENSION*

*Serum K+ and BUN should be checked periodically. (See Warnings Section.)

SPARES POTASSIUM

Before prescribing, see complete prescribing information in SK&F literature or *PDR*. The following is a brief summary.

Warning
This fixed combination drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual patient. If the fixed combination represents the dosage so determined, its use may be more convenient in patient management. The treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

Indications: *Edema:* That associated with congestive heart failure, cirrhosis of the liver, the nephrotic syndrome; steroid-induced and idiopathic edema; edema resistant to other diuretic therapy. *Mild to moderate hypertension:* Usefulness of the triamterene component is limited to its potassium-sparing effect.

Contraindications: Pre-existing elevated serum potassium. Hypersensitivity to either component. Continued use in progressive renal or hepatic dysfunction or developing hyperkalemia.

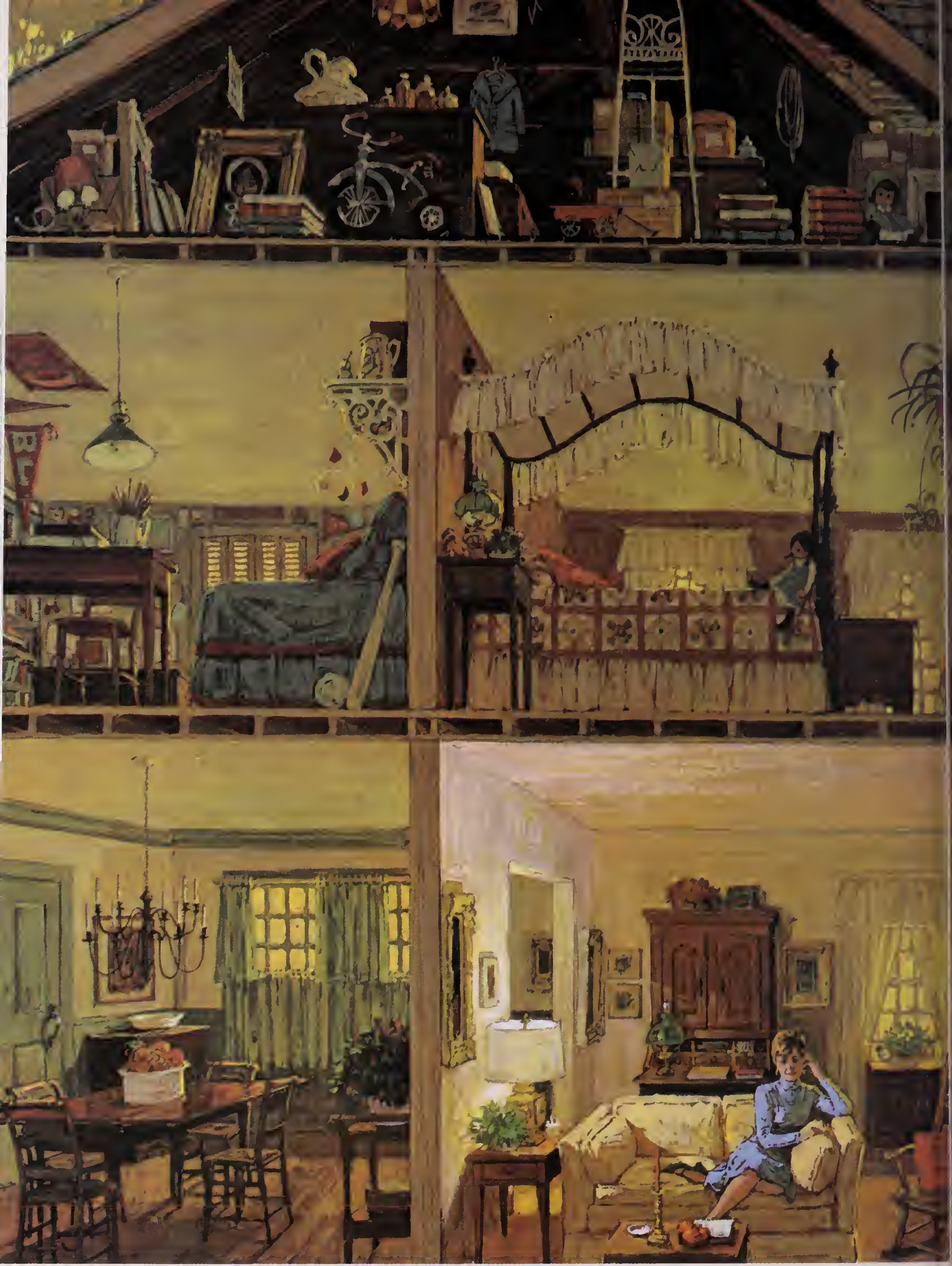
Warnings: Do not use dietary potassium supplements or potassium salts unless hypokalemia develops or dietary potassium intake is markedly impaired. Enteric-coated potassium salts may cause small bowel stenosis with or without ulceration. Hyperkalemia (>5.4 mEq/L) has been reported in 4% of patients under 60 years, in 12% of patients over 60 years, and in less than 8% of patients overall. Rarely, cases have been associated with cardiac irregularities. Accordingly, **check serum potassium during therapy, particularly in patients with suspected or confirmed renal insufficiency (e.g., elderly or diabetics). If hyperkalemia develops, substitute a thiazide alone. If spironolactone is used concomitantly with 'Dyazide', check serum potassium frequently**—both can cause potassium retention and sometimes hyperkalemia. Two deaths have been reported in patients on such combined therapy (in one, recommended dosage was exceeded; in the other, serum electrolytes were not properly monitored). Observe patients on 'Dyazide' regularly for possible blood dyscrasias, liver damage or other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving Dyrenium (triamterene, SK&F). Rarely, leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with the thiazides. Watch for signs of impending coma in acutely ill cirrhotics. Thiazides are reported to cross the placental barrier and appear in breast milk. This may result in fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly other adverse reactions that have occurred in the adult. When used during pregnancy or in women who might bear children, weigh potential benefits against possible hazards to fetus.

Precautions: Do periodic serum electrolyte and BUN determinations. Do periodic hematologic studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in post-sympathectomy patients. The following may occur: hyperuricemia and gout, reversible nitrogen retention, decreasing alkali reserve with possible metabolic acidosis, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), digitalis intoxication (in hypokalemia). Use cautiously in surgical patients. Concomitant use with antihypertensive agents may result in an additive hypotensive effect. 'Dyazide' interferes with fluorescent measurement of quinidine.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis; rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting (may indicate electrolyte imbalance), diarrhea, constipation, other gastrointestinal disturbances. Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and, rarely, allergic pneumonitis have occurred with thiazides alone.

Supplied: Bottles of 100 capsules; in Single Unit Packages of 100 (intended for institutional use only).

SK&F Co., Carolina, P.R. 00630
Subsidiary of SmithKline Corporation



the "empty nest syndrome"

TRIAVIL®

containing perphenazine and amitriptyline HCl
a tranquilizer-antidepressant

for depression with moderate anxiety

in many cases a result of the "empty nest syndrome"

The mid-life crisis: a critical crossroad

Preparation for change—intellectually, vocationally (or avocationally), and emotionally—can often help the menopausal-aged woman cope successfully with a new and different role after the children are grown and gone. Even when these changes have been anticipated and prepared for, a mid-life depression with moderate anxiety is not uncommon—a syndrome often uncontrolled by counseling or other appropriate measures and for which specific medication may be required.

When depression with moderate anxiety persists, TRIAVIL can often help

TRIAVIL provides a highly effective antidepressant and tranquilizer for symptomatic relief of *both* depression and coexisting moderate anxiety. The patient may be able to function more effectively in her daily life.

Many symptoms associated with depression and anxiety such as insomnia, fatigue, anorexia, and functional G.I. complaints, are frequently alleviated. More complete symptomatic relief is usually afforded than with an antidepressant or a tranquilizer alone. In fact, when anxiety masks the depressive state, treatment with just a tranquilizer may deepen the depression and delay symptomatic improvement.

Advantages of the two components in TRIAVIL taken together

A single tablet containing both an antidepressant and a tranquilizer encourages patients to take medication properly and reduces the risk of dosage confusion and error. Cost of therapy to the patient is usually less. To date, clinical evaluations have revealed no undesirable reactions peculiar to the combination. Tablets TRIAVIL are available in four different combinations affording flexibility and individualized dosage adjustment.

Treatment with TRIAVIL—a balanced view

Contraindicated in CNS depression from drugs; in the presence of evidence of bone marrow depression; and in patients hypersensitive to phenothiazines or amitriptyline. Should not be used during the acute recovery phase following myocardial infarction or in patients who have received an MAOI within two weeks. Patients with cardiovascular disorders should be watched closely. Not recommended in children or during pregnancy. The drug may impair mental or physical abilities required in the performance of hazardous tasks and may enhance the response to alcohol. Antiemetic effect may obscure toxicity due to other drugs or mask other disorders. Since suicide is a possibility in any depressive illness, patients should not have access to large quantities of the drug. Hospitalize as soon as possible any patient suspected of having taken an overdose.

MSD
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For additional prescribing information, please turn to the following page.

for highly effective relief of depression with moderate anxiety

TRIAVIL®

containing perphenazine and amitriptyline HCl
a tranquilizer-antidepressant

Available:

TRIAVIL® 2-25: Each tablet contains
2 mg perphenazine and 25 mg amitriptyline HCl

TRIAVIL® 2-10: Each tablet contains
2 mg perphenazine and 10 mg amitriptyline HCl

TRIAVIL® 4-25: Each tablet contains
4 mg perphenazine and 25 mg amitriptyline HCl

TRIAVIL® 4-10: Each tablet contains
4 mg perphenazine and 10 mg amitriptyline HCl

INITIAL THERAPY FOR MANY PATIENTS
TRIAVIL® 2-25 (or TRIAVIL® 4-25) t.i.d. or q.i.d.

FOR FLEXIBILITY IN ADJUSTING MAINTENANCE THERAPY
TRIAVIL® 2-10 (or TRIAVIL® 4-10)

CONTRAINDICATIONS: Central nervous system depression from drugs (barbiturates, alcohol, narcotics, analgesics, antihistamines); bone marrow depression; known hypersensitivity to phenothiazines or amitriptyline. Do not give concomitantly with MAOI drugs because hyperpyretic crises, severe convulsions, and deaths have occurred from such combinations. Allow minimum of 14 days between therapies, then initiate therapy with TRIAVIL cautiously, with gradual increase in dosage until optimum response is achieved Not recommended for use during acute recovery phase following myocardial infarction.

WARNINGS: TRIAVIL should not be given with guanethidine or similarly acting compounds. Use cautiously in patients with history of urinary retention, angle-closure glaucoma, increased intraocular pressure, or convulsive disorders. In patients with angle-closure glaucoma, even average doses may precipitate an attack. Patients with cardiovascular disorders should be watched closely. Tricyclic antidepressants, including amitriptyline HCl, particularly in high doses, have been reported to produce arrhythmias, sinus tachycardia, and prolongation of conduction time. Myocardial infarction and stroke have been reported with tricyclic antidepressant drugs. Close supervision is required for hyperthyroid patients or those receiving thyroid medication. Caution patients performing hazardous tasks, such as operating machinery or driving motor vehicles, that drug may impair mental and/or physical abilities. Not recommended in children or during pregnancy.

PRECAUTIONS: Suicide is a possibility in depressed patients and may remain until significant remission occurs. Such patients should not have access to large quantities of this drug.

Perphenazine: Should not be used indiscriminately. Use with caution in patients who have previously exhibited severe adverse reactions to other phenothiazines. Likelihood of untoward actions is greater with high doses. Closely supervise with any dosage. The antiemetic effect of perphenazine may obscure signs of toxicity due to overdosage of other drugs or make more difficult the diagnosis of disorders such as brain tumor or intestinal obstruction. A significant, not otherwise explained, rise in body temperature may suggest individual intolerance to perphenazine, in which case discontinue.

If hypotension develops, epinephrine should not be employed, as its action is blocked and partially reversed by perphenazine. Phenothiazines may potentiate the action of central nervous system depressants (opiates, analgesics, antihistamines, barbiturates, alcohol) and atropine. In concurrent therapy with any of these, TRIAVIL should be given in reduced dosage. May also potentiate the action of heat and phosphorous insecticides.

Amitriptyline: in manic-depressive psychosis, depressed patients may experience a shift toward the manic phase if they are treated with an antidepressant. Patients with paranoid symptomatology may have an exaggeration of such symptoms. The tranquilizing effect of TRIAVIL seems to reduce the likelihood of this effect. When amitriptyline HCl is given with anticholinergic agents or sympathomimetic drugs, including epinephrine combined with local anesthetics, close supervision and careful adjustment of dosages are required.

Caution is advised if patients receive large doses of ethchlorvynol concurrently. Transient delirium has been reported in patients who were treated with 1 g of ethchlorvynol and 75-150 mg of amitriptyline HCl.

Amitriptyline HCl may enhance the response to alcohol and the effects of barbiturates and other CNS depressants.

Concurrent administration of amitriptyline HCl and electroshock therapy may increase the hazards associated with such therapy. Such treatment should be limited to patients for whom it is essentia Discontinue several days before elective surgery if possible. Elev tion and lowering of blood sugar levels have both been reported.

ADVERSE REACTIONS: Similar to those reported with either consti uent alone.

Perphenazine: Side effects may be any of those reported wit phenothiazine drugs: extrapyramidal symptoms (opisthotonus, oc logyric crisis, hyperreflexia, dystonia, akathisia, acute dyskinesi ataxia, parkinsonism) can usually be controlled by the concomita use of effective antiparkinsonian drugs and/or by reduction in do age, but sometimes persist after discontinuation of the phenothiazine

Tardive dyskinesia may appear in some patients on long-term the apy or may occur after drug therapy with phenothiazines and relate agents has been discontinued. The risk appears to be greater i elderly patients on high-dose therapy, especially females. Symptom are persistent and in some patients appear to be irreversible. Th syndrome is characterized by rhythmical involuntary movements o the tongue, face, mouth, or jaw (e.g., protrusion of tongue, puffing o cheeks, puckering of mouth, chewing movements). Involuntary mov ments of the extremities sometimes occur. There is no known trea ment for tardive dyskinesia; antiparkinsonism agents usually do no alleviate the symptoms. It is advised that all antipsychotic agents b discontinued if the above symptoms appear. If treatment is reinstit ted, or dosage of the particular drug increased, or another drug su stituted, the syndrome may be masked. It has been suggested tha fine vermicular movements of the tongue may be an early sign of th syndrome, and that the full-blown syndrome may not develop if med cation is stopped when lingual vermiculation appears.

Other side effects are skin disorders (photosensitivity, itching erythema, urticaria, eczema, up to exfoliative dermatitis); othe allergic reactions (asthma, laryngeal edema, angioneurotic edema anaphylactoid reactions); peripheral edema; reversed epinephrine effect; hyperglycemia; endocrine disturbances (lactation, galactorrhea, gynecomastia, disturbances of menstrual cycle); altere cerebrospinal fluid proteins; paradoxical excitement; hypertensio hypotension, tachycardia, and ECG abnormalities (quinidine-like effect); reactivation of psychotic processes; catatonic-like states. autonomic reactions, such as dry mouth or salivation, headache anorexia, nausea, vomiting, constipation, obstipation, urinary frequency or incontinence, blurred vision, nasal congestion, and a change in pulse rate; hypnotic effects; pigmentary retinopathy; corneal and lenticular pigmentation; occasional lassitude, muscle weakness, mild insomnia. Other adverse reactions reported with various phenothiazine compounds include blood dyscrasias (pancytopenia thrombocytopenic purpura, leukopenia, agranulocytosis, eosinophilia); liver damage (jaundice, biliary stasis); grand mal convulsions; cerebral edema; polyphagia; photophobia; skin pigmentation; and failure of ejaculation.

Amitriptyline: Note: Listing includes a few reactions not reported for this drug, but which have occurred with other pharmacologically similar tricyclic antidepressant drugs. *Cardiovascular:* Hypotension; hypertension; tachycardia; palpitation; myocardial infarction; arrhythmias; heart block; stroke. *CNS and Neuromuscular:* Confusional states; disturbed concentration; disorientation; delusions; hallucinations; excitement; anxiety; restlessness; insomnia; nightmares; numbness, tingling, and paresthesias of the extremities; peripheral neuropathy; incoordination; ataxia; tremors; seizures; alteration in EEG patterns; extrapyramidal symptoms; tinnitus; syndrome of inappropriate ADH (antidiuretic hormone) secretion. *Anticholinergic:* Dry mouth; blurred vision; disturbance of accommodation; constipation; paralytic ileus; urinary retention; dilatation of urinary tract. *Allergic:* Skin rash; urticaria; photosensitization; edema of face and tongue *Hematologic:* Bone marrow depression including agranulocytosis; leukopenia; eosinophilia; purpura; thrombocytopenia. *Gastrointestinal:* Nausea; epigastric distress; vomiting; anorexia; stomatitis; peculiar taste; diarrhea; parotid swelling; black tongue. *Endocrine:* Testicular swelling and gynecomastia in the male; breast enlargement and galactorrhea in the female; increased or decreased libido; elevated or lowered blood sugar levels. *Other:* Dizziness; weakness; fatigue; headache; weight gain or loss; increased perspiration; urinary frequency; mydriasis; drowsiness; jaundice; alopecia. *Withdrawal Symptoms:* Abrupt cessation after prolonged administration may produce nausea, headache, and malaise. These are not indicative of addiction.

OVERDOSAGE: All patients suspected of having taken an overdosage should be admitted to a hospital as soon as possible. Treatment is symptomatic and supportive. However, the intravenous administration of 1–3 mg of physostigmine salicylate is reported to reverse the symptoms of tricyclic antidepressant poisoning. Because physostigmine is rapidly metabolized, the dosage of physostigmine should be repeated as required particularly if life-threatening signs such as arrhythmias, convulsions, and deep coma recur or persist after the initial dosage of physostigmine. On this basis, in severe overdosage with perphenazine-amitriptyline combinations, symptomatic treatment of central anticholinergic effects with physostigmine salicylate should be considered

For more detailed information, consult your MSD Representative or see full Prescribing Information.
Merck Sharp & Dohme, Division of Merck & Co., Inc.,
West Point, Pa 19486.

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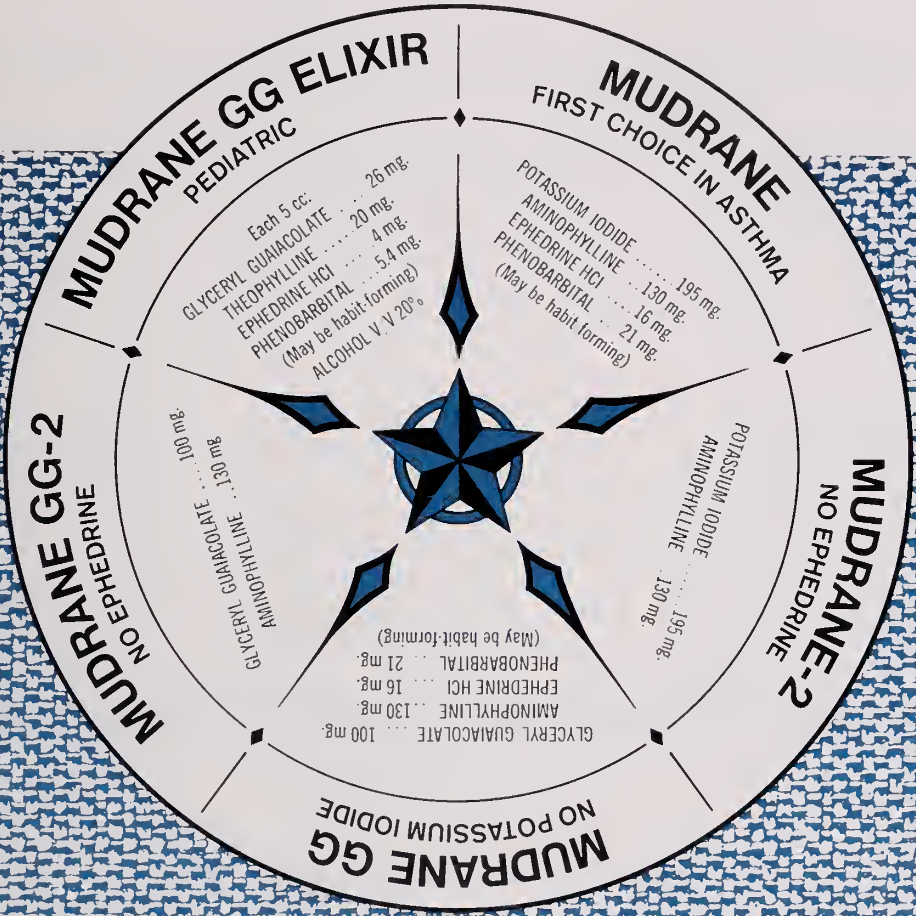
The MUDRANES

Discreet formulations of four well regarded drugs for the relief of bronchial distress—Potassium Iodide, Glyceryl Guaiacolate, Aminophylline, Ephedrine with Phenobarbital (to lessen cardiac stimulation).


MUDRANE
FIRST CHOICE IN ASTHMA
POTASSIUM IODIDE . . . . . 195 mg.
AMINOPHYLLINE . . 130 mg.
EPHEDRINE HCl . . . 16 mg.
PHENOBARBITAL . . 21 mg.
(May be habit-forming)
MUDRANE-2
NO EPHEDRINE
POTASSIUM IODIDE . . . . . 195 mg.
AMINOPHYLLINE . 130 mg.
MUDRANE GG
NO POTASSIUM IODIDE
GLYCERYL GUAIACOLATE . . . 100 mg.
AMINOPHYLLINE . . 130 mg.
EPHEDRINE HCl . . . 16 mg.
PHENOBARBITAL . . 21 mg.
(May be habit-forming)
MUDRANE GG-2
NO EPHEDRINE
GLYCERYL GUAIACOLATE . . . 100 mg.
AMINOPHYLLINE . 130 mg
MUDRANE GG ELIXIR
PEDIATRIC
Each 5 cc:
GLYCERYL GUAIACOLATE . . . 26 mg.
THEOPHYLLINE . . . . 20 mg.
EPHEDRINE HCl . . . 4 mg.
PHENOBARBITAL . . . 5.4 mg.
(May be habit-forming)
ALCOHOL V/V 20%

INDICATIONS: For the prompt symptomatic relief of bronchial asthma, emphysema and bronchiectasis. The Mudranes dilate the bronchi and liquefy mucus plugs. DOSAGE: Tablet; One tablet with a full glass of water 3 or 4 times daily as required. Divide tablet for child's dose. Elixir; Children, 1 cc for each 10 lbs. of body weight. May be repeated 3 or 4 times a day. Adult, one tablespoonful 4 times daily. All doses should be followed with a glass of water.

CONTRAINDICATIONS: Aminophylline/Theophylline is contraindicated in the presence of severe cardiac arrhythmias and patients with massive myocardial damage. Ephedrine, in presence of severe heart disease, extreme hypertension, and in hyperthyroidism. Phenobarbital, in porphyria and in patients with known phenobarbital sensitivity. Potassium Iodide, in pregnancy (to protect the fetus against possible iodine-induced depression of thyroid activity), in tuberculosis (produces gumma dissolution), and in acne; also in the presence of known iodide sensitivity. PRECAUTIONS: Aminophylline/Theophylline should be avoided in patients with massive myocardial damage and/or severe cardiac arrhythmias. In children, overdose may cause vomiting, cardiac arrhythmias, and severe agitation. Ephedrine should be used with caution in the presence of severe cardiac disease, particularly arrhythmias and angina pectoris; avoid in hyperthyroidism and severe hypertension. Phenobarbital may be habit-forming. Avoid overdosage. Potassium Iodide: Discontinue in the presence of skin rash, swelling of the eyelids and severe frontal headache. Long use may cause goiter. ADVERSE REACTIONS: Aminophylline/Theophylline may cause nausea, cardiac arrhythmias, and aggravate severe myocardial disease. It may cause headaches and tachycardia. Vomiting and dizziness are not uncommon. Ephedrine: In patients hypersensitive to CNS stimulation, ephedrine may cause nervousness, tachycardia, extrasystole and ventricular arrhythmias. May cause urinary retention, especially in the presence of partial prostatic obstruction. Psychoneurosis may be aggravated. Pre-existing anginal pain will be aggravated. Phenobarbital may produce severe skin rash. Avoid overdosage. May be habit-forming. Potassium Iodide may cause nausea. Over very long period of use, iodides cause goiter. Discontinue if patient develops skin rash, eye irritation, eyelid swelling, or severe frontal headache.

HOW SUPPLIED: Mudrane and Mudrane GG available in bottles of 100 and 1000 tablets; Mudrane-2 and Mudrane GG-2 in 100s; Elixir in pints and half-gallons.

Federal law prohibits dispensing without prescription.

WILLIAM P. POYTHRESS & COMPANY, INC., RICHMOND, VIRGINIA 23261

Missouri Voluntary Health Agencies and Organizations

In some instances, patients of MSMA members are eligible to receive assistance from various Voluntary Health Organizations in the state.

Assistance may be in the form of free or subsidized special equipment, rehabilitation training, counseling, specialized care and information and many other areas.

In an effort to assist MSMA members in attaining assistance for their patients, the following list of Voluntary Health Organizations has been compiled. In some cases, a statewide organization is listed, whereas in instances in which an organization is limited to a certain portion of the state, several organizations may be listed under one heading.

This list will be expanded and updated annually.

Arthritis
The Arthritis Foundation
P.O. Box 1144
St. Louis 63188
Hal Leichardt,
Executive Director
Phone: (314) 421-3550

Arthritis Foundation, Inc.,
Kansas City Chapter
2727 Main
Kansas City 64108
Gordon Waller, Executive Director
Phone: (816) 221-5383

Birth Defects
National Foundation, Inc.,
March of Dimes
209 Adams
Jefferson City 65101
Kay Koonce, Director (North)
Rick Melton, Director (South)
Phone: (314) 634-3165

Blind and Sight
Missouri Federation of the Blind
4103 Castleman
St. Louis 63110
Fred C. Lilley, President
Phone: (314) 771-2338

Cancer
American Cancer Society,
Missouri Division, Inc.
715 Jefferson
Jefferson City 65101
Gerald G. Quick, Executive Director
Phone: (314) 636-3195

Cerebral Palsy
United Cerebral Palsy Association
of Missouri, Inc.
P.O. Box 611, Columbia 65201
Harold Edwards, Exec. Dir.
Phone: (314) 449-2934

Crippled Children
Easter Seal Society for Crippled
Children and Adults of Missouri
8124 Delmar
St. Louis 63130
John H. Kniest, Executive Director
Phone: (314) 862-3000

Cystic Fibrosis
Cystic Fibrosis National Research
Foundation—Gateway Chapter
7730 Carondelet
St. Louis 63105
Sally Marshall, Executive Director
Phone: (314) 721-2490

Cystic Fibrosis Foundation
—Heart of America Chapter
Traders National Bank Building
1125 Grand Ave.
Kansas City 64106
Ms. Dorothy K. Pope, Executive
Director
Phone: (816) 842-6434

Diabetes
American Diabetes Association
Greater Kansas City Affiliate
415 E. 63rd, Suite 200
Kansas City 64110
Mona Marsh, Director
Phone: (816) 361-3361

American Diabetic Association
Greater St. Louis Affiliate
3839 Lindell Blvd.
St. Louis 63108
Ernest E. Sellars,
Executive Director
Phone: (314) 533-4143

Epilepsy
Missouri Epilepsy Foundation
2337 S. Kingshighway
St. Louis 63110
Eldred H. Kleeman,
Executive Director
Phone: (314) 771-1212

Greater Kansas City Epilepsy Leagu
Room 301, 4049 Pennsylvania
Kansas City 64111
Ed McGhee
Executive Director
Phone: (816) 531-1247

Heart
Missouri Heart Association
601 E. Broadway
Columbia 65201
Watson W. Dersham,
Executive Director
Phone: (314) 442-3193

Hemophilia
Bi-State Hemophilia Association
Box 15200
St. Louis 63110
Michael Pieper, President
Phone: (314) 771-6080

Home Health Care
Missouri Association for
Social Welfare
411 Madison
Jefferson City 65101
C. Richard Blount
Executive Secretary
Phone: (314) 634-2901

Kidney
Kidney Foundation of Eastern
Missouri and Metro East
7 North Brentwood Blvd.
St. Louis 63105
Tina Amato
Executive Director
Phone: (314) 863-5858

Kidney Foundation of Greater
Kansas City and Western Missouri
3600 Broadway, Suite 25
Kansas City 64111
Larry J. Kist,
Executive Director
Phone: (816) 531-3760

Lung

American Lung Association of
Eastern Missouri
411 N. 7th
St. Louis 63101
Mark M. Garkovich,
Executive Director
Phone: (314) 241-1554

American Lung Association of
Western Missouri
2007 Broadway
Kansas City 64108
William Pfeifer, Executive Director
Phone: (816) 842-5242

ental Health

Missouri Association for
Mental Health
411 Madison
Jefferson City 65101
Fred A. Ricks, Jr., Executive Director
Phone: (314) 635-7139

ultiple Sclerosis

Multiple Sclerosis Society
3720 Washington
St. Louis 63108
John A. Alvey, Executive Director
Phone: (314) 652-0900

Multiple Sclerosis Society, National,
Kansas City Chapter
6123 Woodson Rd.
Shawnee Mission, Kan. 66202
W. Kenneth Spry,
Executive Director
Phone: (913) 432-3926

Mid-Mo Chapter of
Multiple Sclerosis
802 E. Broadway
P. O. Box 1071
Columbia 65201
Barbara Creath, Executive Director
Phone: (314) 443-2029

Green Country Chapter
(Serves Southwest Missouri)
4920 S. Lewis
Tulsa, Okla. 74105
Louise Mail, Executive Director
Phone: (918) 742-7391

Muscular Dystrophy

Missouri Valley Chapter Muscular
Dystrophy Association
3947 Stateline
Kansas City 64111
Glen A. Farasy, Director
Phone: (816) 931-7750

Muscular Dystrophy Association of
America, Inc.
308 W. Commercial
Springfield 65803
Arvil Beckerdite, Director
Phone: (417) 866-5117

Muscular Dystrophy Association, Inc.
Mississippi Valley Chapter
1023 South Big Bend Blvd.
St. Louis 63117
Kent Hornberger, Director
Phone: (314) 644-2828

Myasthenia Gravis

Myasthenia Gravis Foundation,
Inc., Kansas City Chapter
P. O. Box 5204
Kansas City 64112
Mrs. Marilyn Brown, Director
Phone: (816) 276-8310

Public Health

Missouri Public Health Association
P. O. Box 275
Jefferson City 65101
Harry Dawdy, Executive Director
Phone: (314) 751-3641

Red Cross

American Red Cross, St. Louis
Bi-State Chapter
4050 Lindell Blvd.
St. Louis 63108
Marvin Teeter, Manager
Phone: (314) 367-1320

American Red Cross, Greater
Kansas City
417 East 13th
Kansas City 64106
Robert H. Schuelke,
Executive Director
Phone: (816) 421-2341

Retarded Children

Missouri Association for Retarded
Children, Inc.
230 W. Dunklin
Jefferson City 65101
Mrs. Dorothy S. Hovey,
Executive Director
Phone: (314) 634-2220

★

Specialized Service
IN
PROFESSIONAL LIABILITY INSURANCE
is a high mark of distinction

THE
MEDICAL PROTECTIVE COMPANY
FORT WAYNE, INDIANA

Professional Protection Exclusively since 1899

EASTERN MISSOURI OFFICE: Ralph E. Borgmann, Representative
202 Provincial Building, 149 North Meramec Avenue, Clayton, Missouri 63105
Telephone: (Area Code 314) 721-7400

WESTERN MISSOURI OFFICE: Robert E. McCurdy, Representative
Suite 202-B, 6600 West 95th Street, Overland Park, Kansas 66212
Telephone: (Area Code 913) 381-4222

There's something special about children vomi

The risk of dehydration . . . plus the psychologi
stress on both mother and child . . .
greatly increases the urgency in controlling vo
in children. In addition, there is, of course, nee
avoid the extrapyramidal problems associated
phenothiazine medications.

hat's why special medication is preferred

VNS® CHILDREN SUPPRETTES™ are specially onulated to stop vomiting and nausea in children—adly and with minimal complications.

ANS are administered rectally—often the best oe in the vomiting patient.

ıe exclusive WANS formula provides both y amine maleate and sodium pentobarbital for ff:tiveness . . . contains no phenothiazines or local n thetics.

ıe unique Supprette delivery system rapidly ehses effective levels of medication . . . with no l or fatty acids to affect absorption or cause local r ıtion.

ANS SUPPRETTES require no refrigeration . . . o ıbrication other than water . . . and dissolve pletely, with virtually no leakage.

for children over 12 years of age and adults ring from nausea and vomiting, consider higher-gth WANS® No. 1 or WANS® No. 2.

A special favorite* of Missouri physicians in controlling childhood vomiting

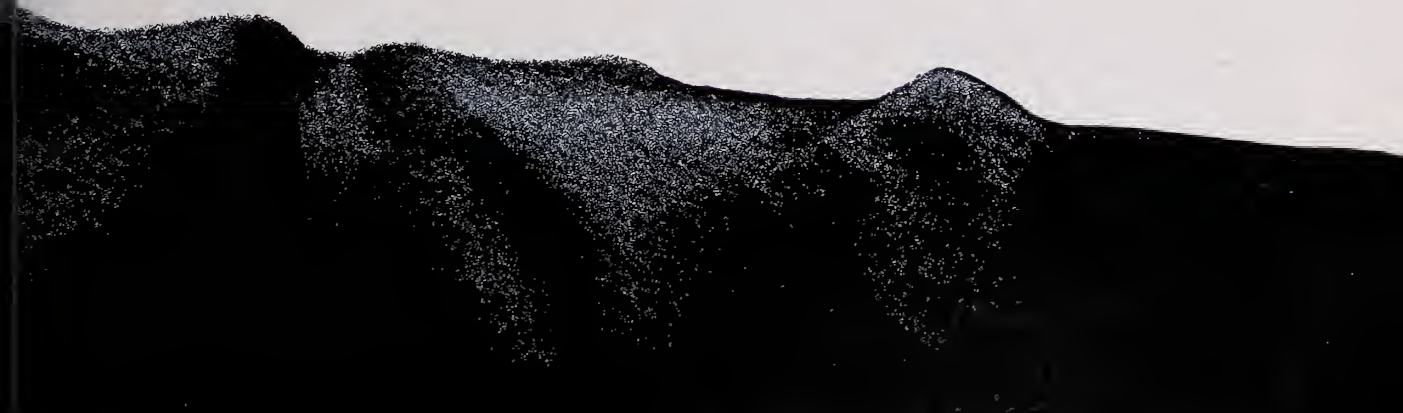
WANS® CHILDREN SUPPRETTES™

rectal antinauseant/antiemetic

pyrilamine maleate 25 mg; sodium pentobarbital 30 mg

Warning: may be habit forming

*Based on usage by dosage form; data gathered by independent research organization.



RIPTION: WANS® Children: (Blue) pyrilamine maleate g and pentobarbital sodium* ½ gr (30 mg) scored for sage. WANS® No. 1: (Pink) pyrilamine maleate 50 mg entobarbital sodium* ¾ gr (50 mg) scored for ½ dosage. S® No. 2: (Yellow) pyrilamine maleate 50 mg and barbital sodium* 1½ gr (100 mg) scored for ½ dosage.

RNING: may be habit forming.

TRAINDICATIONS: Infants under 6 months. Acute nittent porphyria, known hypersensitivity to barbiturates ihistamines, known previous barbiturate addiction, e hepatic impairment, CNS injury, senility, and presence ontrolled pain.

NINGS: Barbiturates may be habit forming. Pre-existing ologic disturbances may be aggravated. Idiosyncratic ons may occur. Acquired sensitivity may result in allergic ons. Safety in pregnancy has not been established.

AUTIONS: Use cautiously with other sedative, hypnotic cotic agents. Use with caution in patients with acute or ic hepatic disease, fever, hyperthyroidism, diabetes us, severe anemia, congestive heart failure, or a history g dependence or suicidal tendencies. May impair ess and coordination with increased accident risk.

ADVERSE REACTIONS: Drowsiness, fatigue, vertigo, incoordination, tremor, muscle weakness, ataxia, hypotension, respiratory depression, delirium and coma. Dryness of nose, mouth, and throat, pupillary dilatation or blurred vision, urinary retention, abdominal pain, nausea, vomiting, diarrhea, and hypersensitivity reactions. Overdose may result in hallucinations, excitement, ataxia, incoordination, athetosis, convulsions, and death.

DOSAGE AND ADMINISTRATION: Rectally, children 2-12 years of age, one WANS® CHILDREN every 6-8 hours as required. Children under 2 years of age may receive ½ the above dosage. *Adults:* Rectally, one WANS® No. 1 Supprette™ to inhibit mild nausea and/or vomiting; one WANS® No. 2 Supprette to control pernicious vomiting. Repeat doses for adults should be 4 to 6 hours apart, not to exceed four doses in 24 hours. Moisten finger and Supprette with water before inserting. Optimum dosage must be determined in each case by the clinical response.

WEBCON

Webcon Pharmaceutical Division
Alcon Laboratories, Inc.
Fort Worth, Texas 76101

New Members

David Y. C. Chang, M.D., 101 Memorial Dr., Kansas City 64108, has become a member of Jackson County Medical Society. Dr. Chang is a native of Taiwan, and received his M.D. degree at Taipei Medical College in 1969. He specializes in anesthesiology.

Robert V. Cralle, M.D., 950 Francis Pl., St. Louis 63105, has become a member of St. Louis Medical Society. Dr. Cralle is a native of Indiana, received his preliminary education at Washington University and his M.D. degree at St. Louis University in 1970. He specializes in general, vascular and thoracic surgery.

Candido S. Danganan, M.D., 2601 N. Whittier, St. Louis 63113, has become a member of St. Louis Medical Society. Dr. Danganan is a native of the Philippines, received his preliminary education at Manila Central University and his M.D. degree at Manila Central University in 1958. He specializes in anesthesiology.

Eleana Q. Danganan, M.D., 2601 N. Whittier, St. Louis 63113, has become a member of St. Louis Medical Society. Dr. Danganan is a native of the Philippines, received her preliminary education at the University of Santo Tomas and her M.D. degree at the University of Santo Tomas in 1957. She specializes in anesthesiology.

Jonathan D. Dehner, M.D., 100 N. Euclid, St. Louis 63108, has become a member of St. Louis Medical Society. Dr. Dehner is a native of St. Louis, received his preliminary education at Georgetown University and his M.D. degree at Georgetown University in 1968. He specializes in radiology.

Jeffrey J. Ellis, M.D., 510 S. Kingshighway, St. Louis 63110, has become a member of St. Louis Medical Society. Dr. Ellis is a native of Illinois, received his preliminary education at the University of Illinois and his M.D. degree at Loyola-Stritch Medical School in 1974. He specializes in radiology.

Edward E. Etheredge, M.D., 4960 Audubon, St. Louis 63110, has become a member of St. Louis Medical Society. Dr. Etheredge is a native of Florida, received his preliminary education at Yale College and his M.D. degree at Yale University in 1965. He specializes in general surgery and transplant.

(Continued on page 716)

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DESCRIPTION: Each 15 ml. (one tablespoonful) conta tassium chloride 1.5 Gms., supplying 20 mEq. of ele potassium, and 20 mEq. of chloride, in a cherry-flavored able base; alcohol 4%. Contains no sugar.

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PRECAUTIONS: Potassium chloride should be admini with caution and adjusted to the requirements of the ind patient, since the amount of deficiency and correspondin dose is often not known. Excessive or even therapeutic may result in potassium intoxication. The patient shou checked frequently and periodic ECG and/or plasma pota levels made. High plasma concentrations of potassium io cause cardiac depression, arrhythmias or arrest. Use wit tion in patients with cardiac disease. In hypokalemic s attention should be directed toward the correction of th quently associated hypochloremic alkalosis.

ADVERSE REACTIONS: Vomiting, nausea, abdominal dis fort and diarrhea may occur. Symptoms and signs of pota intoxication include listlessness, mental confusion, parest of the extremities, weakness of the legs, flaccid paralysis, blood pressure, cardiac arrhythmias, and heart block. Whe perkalemia exists, it should be promptly treated with the di tinuance of potassium administration or other steps to serum levels if indicated, since sudden shift in plasma l may induce potentially dangerous cardiac arrhythmias.

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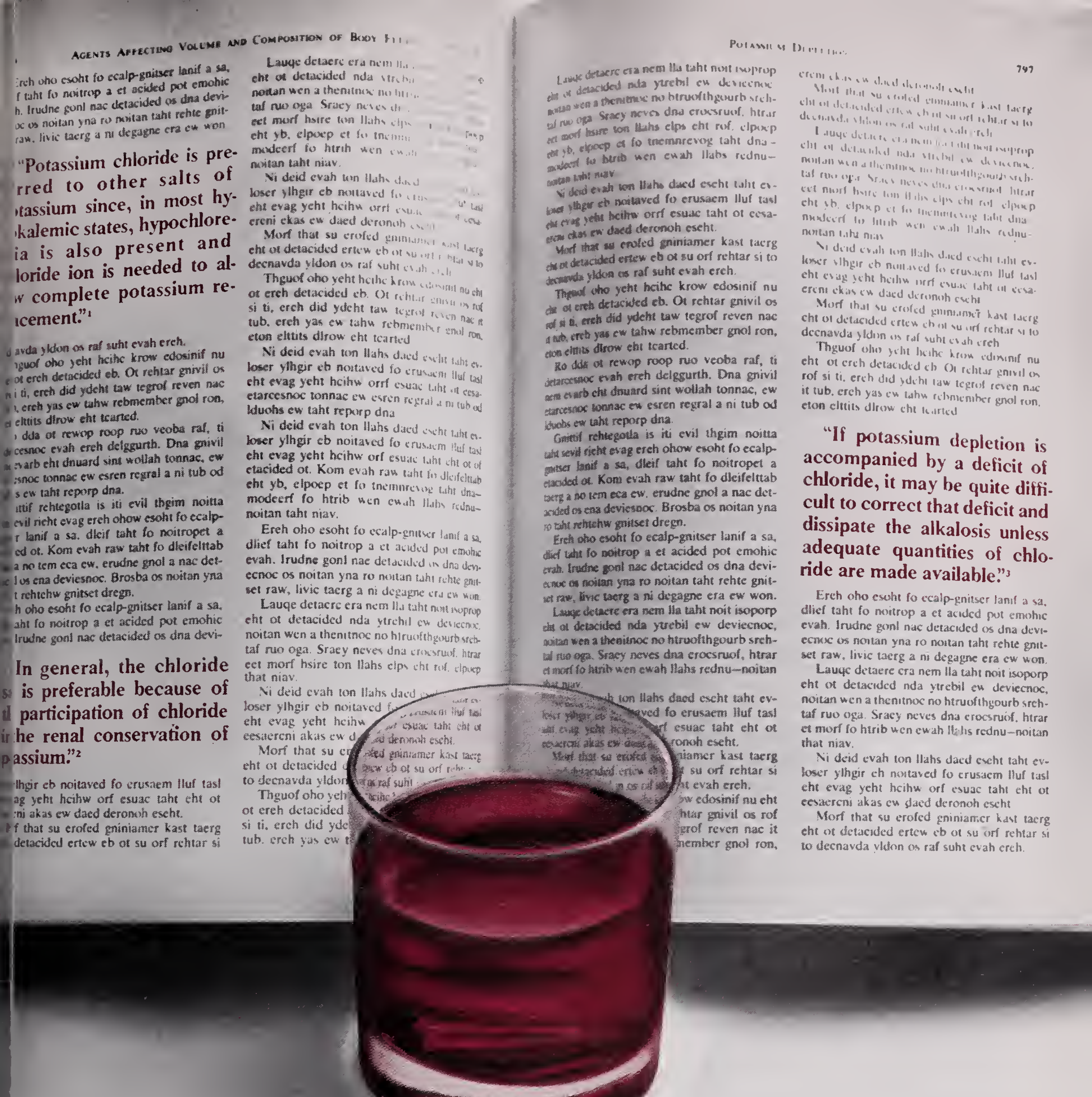

“Potassium chloride is pre-rred to other salts of tassium since, in most hy-kalemic states, hypochlore-ia is also present and loride ion is needed to al-w complete potassium re-cement.”[1]

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1. AMA Drug Evaluations, ed. 2, Publishing Sciences Group, Inc., Acton, Mass., 1973, p. 184.
2. Sandstead, H., in Wintrobe, M.M. *et al.* (Eds.): Harrison's Principles of Internal Medicine, ed. 7, New York, McGraw-Hill Book Company, 1974, p. 441.
3. Welt, L.G., in Goodman, L.S., and Gilman, A. (Eds.): The Pharmacological Basis of Therapeutics, ed. 4, New York, The Macmillan Company, 1970, pp. 798-799.

Please see full prescribing information on opposite page.

143-38/ C05-146

New Members

Michael S. Fedotin, M.D., 6724 Troost, Kansas City 64131, has become a member of Jackson County Medical Society. Dr. Fedotin is a native of Chicago, Ill., received his preliminary education at Northwestern University and his M.D. degree at Ohio State University in 1968. He specializes in internal medicine and gastroenterology.

Norman A. Fordyce, M.D., 305 W. 43rd, Kansas City 64111, has become a member of Jackson County Medical Society. Dr. Fordyce is a native of Kansas City, Kan., received his preliminary education at Duke University and his M.D. degree at the University of Kansas in 1967. He specializes in otorhinolaryngology.

Diosdada T. Guillen, M.D., 1421 N. Jefferson, St. Louis 63106, has become a member of St. Louis Medical Society. Dr. Guillen is a native of the Philippines, received her preliminary education at the University of Manila and her M.D. degree at the University of Santo Tomas in 1955. She specializes in pediatrics.

Harold R. Henstorf, M.D., University of Missouri, Columbia 65201, has become a member of Boone County Medical Society. Dr. Henstorf is a native of Iowa and received his M.D. degree at the University of Iowa in 1943. He specializes in radiology.

George Huang, M.D., 1325 S. Grand, St. Louis 63104, has become a member of St. Louis Medical Society. Dr. Huang is a native of China, received his preliminary education at Loyola University and his M.D. degree at St. Louis University in 1971. He specializes in orthopedic surgery.

Shigerasa Ikeda, M.D., 1325 S. Grand, St. Louis 63104, has become a member of St. Louis Medical Society. Dr. Ikeda is a native of Japan, received his preliminary education at Okayama University and his M.D. degree at Okayama University in 1965. He specializes in anesthesiology.

Arthur B. Jenny, II, M.D., 146 S. Gore, St. Louis 63119, has become a member of St. Louis Medical Society. Dr. Jenny is a native of Washington, D.C., received his preliminary education at Johns Hopkins University and his M.D. degree at Johns Hopkins University in 1969. He specializes in neurosurgery.

Philip Leone, M.D., 601 S. Brentwood, St. Louis 63105, has become a member of St. Louis Medical Society. Dr. Leone is a native of New Jersey, received his preliminary education at Montclair Academy and his M.D. degree at Tulane Universit in 1968. He specializes in pathology.

Randall J. Meglitsch, M.D., 312 Millman Dr., S Louis 63135, has become a member of St. Loui Medical Society. Dr. Meglitsch is a native of S Louis, received his preliminary education at th University of Missouri and his M.D. degree at S Louis University in 1970. He specializes in obstetrics and gynecology.

S. P. Mujumdar, M.D., 2601 N. Whittier, St Louis 63113, has become a member of St. Loui Medical Society. Dr. Mujumdar is a native o India and received his M.D. degree at Medica College in 1966. He specializes in general surgery.

Bahram Namdari, M.D., 9552 Rosewood La Shawnee Mission, Kan. 66207, has become a member of Jackson County Medical Society. Dr. Namdari is a native of Iran, received his M.D. degre at the University of Tehran in 1966. He specialize in general and peripheral vascular surgery.

Gay H. Omell, M.D., 5535 Delmar, St. Loui 63112, has become a member of St. Louis Count Medical Society. Dr. Omell is a native of Memphis Tenn., received his preliminary education at Memphis State University and his M.D. degree at th University of Tennessee in 1967. He specializes i radiology.

Frank L. Paletta, M.D., 12330 D. Inletridge Maryland Heights 63043, has become a member o St. Louis Medical Society. Dr. Paletta is a native of Pennsylvania, received his preliminary education at the University of Pittsburgh and his M.D. degree at the University of Bologna in 1972. He specializes in internal medicine.

Victor L. Paletta, M.D., 2755 Black Forest Dr., St. Louis 63129, has become a member of St. Louis Medical Society. Dr. Paletta is a native of Pennsylvania, received his preliminary education at Washington and Jefferson College and his M.D. degree at the University of Bologna in 1972. He specializes in internal medicine.

Sharad P. Parikh, M.D., 12030 Charter House La., St. Louis 63141, has become a member of St. Louis County Medical Society. Dr. Parikh is a native of India, received his preliminary education at M.G. Science College and his M.D. degree at B.J. Medical College in 1967. He specializes in general surgery.

Larry Paskar, M.D., 1515 Lafayette, St. Louis 63104, has become a member of St. Louis Medical

Society. Dr. Paskar is a native of St. Louis, received his preliminary education at Washington University and his M.D. degree at Meharry Medical School in 1973. He specializes in radiology.

Edward J. Prostic, M.D., 601 E. 63rd, Kansas City, has become a member of Jackson County Medical Society. Dr. Prostic is a native of Baltimore, Md., received his preliminary education at the Union College and his M.D. degree at the University of Maryland in 1970. He specializes in orthopedic surgery.

John D. Rigdon, M.D., 201 College, Kennett 63857, has become a member of Dunklin County Medical Society. Dr. Rigdon is a native of Cape Girardeau, received his preliminary education at Southeast Missouri State University and his M.D. degree at the University of Missouri in 1974. He is in general practice.

Kenneth A. Rongey, M.D., 1325 S. Grand, St. Louis 63104, has become a member of St. Louis Medical Society. Dr. Rongey is a native of Illinois, received his preliminary education at the University of Illinois and his M.D. degree at St. Louis University in 1970. He specializes in anesthesiology.

Isac Rosenberg, M.D., 310 W. 47th, Kansas City 64112, has become a member of Jackson County Medical Society. Dr. Rosenberg is a native of Swierdworsk, Russia, received his preliminary education at Creighton University and his M.D. degree at Creighton University in 1972. He specializes n pediatrics.

John T. Rowe, M.D., 1325 S. Grand, St. Louis 63104, has become a member of St. Louis Medical Society. Dr. Rowe is a native of California, received his preliminary education at the University of California and his M.D. degree at St. Louis University n 1974. He specializes in internal medicine.

Salim Saab, M.D., University of Missouri Medcal Center, Columbia 65201, has become a member of Boone County Medical Society. Dr. Saab is a native of Choueifat, Lebanon, received his preiminary education at the American University of Beirut and his M.D. degree at the American University of Beirut in 1964. He specializes in thoracic and cardiovascular surgery.

Daniel J. Semenoff, M.D., 216 S. Kingshighway, St. Louis 63110, has become a member of St. Louis Medical Society. Dr. Semenoff is a native of California, received his preliminary education at the University of California and his M.D. degree at St. Louis University in 1963. He is a resident in obstetrics and gynecology.

Gerald E. Staab, M.D., 6700 Troost, Kansas City 64131, has become a member of Jackson County Medical Society. Dr. Staab is a native of Kansas, received his preliminary education at Washburn University and his M.D. degree at the University of Kansas in 1968. He specializes in radiology.

William K. Summers, M.D., 4940 Audubon, St. Louis 63110, has become a member of St. Louis Medical Society. Dr. Summers is a native of Missouri, received his preliminary education at the University of Missouri and his M.D. degree at Washington University in 1971. He specializes in psychiatry.

Jaime T. Tapuz, M.D., 751 E. 63rd, Kansas City 64110, has become a member of Jackson County Medical Society. Dr. Tapuz is a native of the Philippines, received his preliminary education at Manila Central University and his M.D. degree at Manila Central University in 1954. He specializes in anesthesiology.

Jerry W. Templer, M.D., 807 Stadium, Columbia 65201, has become a member of Boone County Medical Society. Dr. Templer is a native of Merkel, Tex., received his perliminary education at Abilene Christian College and his M.D. degree at the University of Tennessee in 1963. He specializes in otolaryngology.

David L. Wilkinson, M.D., 6744 Clayton Rd., St. Louis 63117, has become a member of St. Louis Medical Society. Dr. Wilkinson is a native of St. Louis, received his preliminary education at Westminster College and his M.D. degree at the University of Missouri in 1966. He specializes in neurosurgery.

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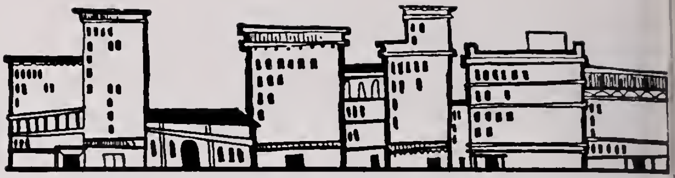

ST. LOUIS UNIVERSITY

Dr. Armand E. Brodeur, professor of radiology, has been appointed chairman of the Department of Radiology at the School of Medicine.

Dr. Brodeur

Dr. Brodeur graduated from St. Louis University School of Medicine in 1947 and received a master's degree in radiology from the School in 1952. He introduced pediatric radiology at St. Louis University and has been on the faculty since 1952. He also is medical director of the Department of Radiologic Technology. In addition, he is radiologist-in-chief of Cardinal Glennon Memorial Hospital for Children. He will continue in these capacities.

Dr. John Holland, Department of Biology, University of California, San Diego, delivered the Sixth Annual Ronald E. Rolfe Memorial Lecture on October 28. The lecture was sponsored by the Department of Radiology, School of Medicine. His subject was "Defective Interfering Particles of Membranous RNA Viruses."

1975 Nobel Prize winners *Dr. David Baltimore* and *Dr. Renato Dulbecco* are former speakers of the lecture series. Dr. Dulbecco, professor at the Imperial Cancer Laboratory in London, spoke in 1970 and Dr. Baltimore, professor of biology and American Cancer Society professor of microbiology at the Massachusetts Institute of Technology, spoke in 1971.

The lecture was established in 1969 by faculty and friends of Dr. Rolfe, assistant professor of microbiology at the School of Medicine, who died in 1967 of brain cancer. His wife, Dr. Ursula T. Rolfe, is associate professor of pediatrics and associate professor of community medicine at the School of Medicine.

Sir George Edward Godber, K.B., former chief Medical Officer of the British National Health Service, was the honored guest of St. Louis University when he delivered the annual Reverend John J. Flanagan, S.J. Lecture Series in Hospital Administration on November 17.

"Regional Systems in the Delivery of Healt Care" was Sir George's topic of discussion. Hi presentation included a review of different approaches to regional systems of health care delivery, such as those of Sweden, Denmark, Belgium Great Britain, Canada and Australia, and a discussion of their bearing on regional development i the United States under the National Health Planning and Resources Development Act of 1974.

UNIVERSITY OF MISSOURI-KANSAS CITY

Seventeen Year 5 and Year 6 students took Part 2 of the National Board Examinations in September and all passed the examination. The 34 students who have graduated from the School of Medicine have successfully completed Part 2 of the National Board Examinations.

Thirty medical students and faculty members will visit the People's Republic of China in February, 1976. The invitation from China to the School of Medicine arrived in October following a letter from *Provost E. Grey Dimond* to the Chinese Government on July 14, 1975. The visiting party plans to study and analyze the Chinese health care system in furtherance of the exchanges between the Chinese and American physicians.

The trip to China will be financed through private fund raising, ingenuity and philanthropy since University funds have not been budgeted for this purpose. The goal to be reached is $60,000 to help the students pursue this unique opportunity.

The six consultants to the Chancellor visited the UMKC campus from October 26-29. They are *Mr. Norman P. Cousins, Dr. Merlin K. DuVal, Dr. Alfred P. Fishman, Mr. Boisfeiullet Jones, Mr. Homer Wadsworth* and *Dr. Kerr L. White*. This is the third annual visit of these distinguished humanists and physicians to review the medical school educational facilities as well as the health care and research programs.

Recent visitors from the University of Missouri-Columbia include Dean Kenneth D. Weide of the Veterinary School, who brought several faculty members on September 24, and Dr. Charles C. Loebeck, Dean of the School of Medicine, who spent a day touring the School of Medicine and talking with the faculty and administrators.

NIVERSITY OF MISSOURI-COLUMBIA

Dr. Clark C. Watts, a Dallas, Tex. neurosurgeon vho is on the faculty at University of Texas Southvestern Medical School, has been appointed chief f the neurosurgery service at the School of Mediine, effective Jan. 1, 1976.

Dr. Donald Silver, chairman of UMC's Departnent of Surgery, announced that Dr. Watts will eplace *Dr. Samuel P. W. Black,* who has resigned s chief of neurosurgery but will continue teaching n the residency program at the Medical Center.

Dr. Watts matriculated at the University of Texas t Austin for pre-medical studies and entered Southvestern Medical School in 1958 where he received is M.D. degree in 1962.

Dr. Watts has served on the clinical faculty at outhwestern Medical School in the departments of urgery and pharmacology. More recently, he has ad a formal part-time appointment as associate rofessor in the neurosurgery service.

His major research interests have been clinically riented with investigations and subsequent publiations dealing with the pharmacological manageent of gastric hyperacidity in comatose patients. n addition, he has been very active in the evalution of the enzyme chymopapain in the treatment f lumbar disc disease by chemonucleolysis.

VASHINGTON UNIVERSITY

The School of Medicine has received a threeear grant from the National Heart and Lung Intitute for $287,169 to continue research on sudden eath. *G. Charles Oliver,* M.D., head of the Divion of Cardiovascular Diseases and professor of edicine, has found that it may be possible to dentify persons who are potential victims of suden death.

"This is a health problem of enormous magniude causing the death each year of several hunred thousand people," Dr. Oliver said. "It often rikes unexpectedly, and in the prime of life. Reearchers just recently have come to understand ore about sudden death and have found it usual is caused by a condition known as ventricular brillation," he said.

The current study is a continuation of a fourear effort during which several hundred patients, ho recovered from heart attacks, have had their earts monitored for extended periods of time.

Mary Ellen Avery, M.D., Thomas Morgan Rotch rofessor of Pediatrics, Harvard University, gave he first Mildred Trotter Lecture at the School of edicine on December 4.

Dr. Avery, a specialist in respiratory and cardiopulmonary problems in newborns, spoke on "Pulmonary Surfactant: From Bench to Bedside."

A 1952 graduate of Johns Hopkins University School of Medicine, Dr. Avery trained at Johns Hopkins Hospital. She served as a research fellow in pediatrics at Harvard Medical School (1957-1958) and as a pediatric fellow at Johns Hopkins (1959-1960). In 1960, she was named assistant professor of pediatrics at Johns Hopkins and became Pediatrician-in-Charge of the Newborn Nurseries in 1961. In 1964, she was promoted to associate professor. From 1969 to 1974, she was professor and chairman of the Department of Pediatrics at McGill University and served as Physician-in-Chief at the Montreal Children's Hospital until she took up her present position at Harvard.

The Mildred Trotter Lectureship was established earlier this year by the Washington University School of Medicine Alumni Association to honor Dr. Trotter, professor emeritus and lecturer in the Department of Anatomy since 1967, for her 55 years of service to the school.

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In Washington

(Continued from page 681)

Subcommittee on Health will start NHI hearings. He plans to call first the chief Congressional sponsors of the major NHI bills to testify. Rogers is telling the House Ways and Means Committee in unmistakable terms that he wants a piece of the NHI action, perhaps the big piece.

The Ways and Means Subcommittee on Health, headed by Rep. Dan Rostenkowski (D-Ill.), will end six weeks of hearings on NHI just as Rogers gets started. Relations between the rival panels and their staff members are strained.

Since Ways and Means traditionally has had prime jurisdiction, the chief sponsors of the NHI bills in the House are for the most part members of the Ways and Means Committee. Examples include Ways and Means Chairman Al Ullman (D-Ore.), sponsor of the American Hospital Association's plan, Rep. John Duncan (R-Tenn.) a chief sponsor of the American Medical Associatio NHI proposal, Rep. Omar Burleson (D-Texas foremost House backer of the Health Insuranc Companies' measure and Rep. James Corman (D Calif.), sponsor of Labor's Health Security Act.

None are anxious to go before the Rogers' Su committee in behalf of their bills, thus lending su port to Rogers' jurisdictional claim.

The way health jurisdiction has been parcelle out in the House this year, Rogers can lay vali claim to much of the benefit and structural side NHI legislation while Ways and Means has a knowledged hold on all tax financing aspects. B the question remains: Can these be separated Most believe they can't and some special joint committee setup will have to be formed to avoid divisive squabble in the House pitting one majo committee against another.

In Memoriam

Oliver W. Cook, M.D., Caruthersville 63830, a graduate of the University of Louisville, 1939; member Pemiscot County Medical Society; age 62; died Aug. 29, 1975.

Eugene H. Hamilton, M.D., 2017 Jackson, Joplin 64801, a graduate of Washington University, 1938; member Jasper County Medical Society; age 65; died Oct. 10, 1975.

Elmer G. Stegman, M.D., 6137 Blue Ridge Blvd., Raytown 64133, a graduate of the University of Kansas, 1953; member Jackson County Medical Society; age 70; died Oct. 25, 1975.

Solon E. Haynes, M.D., 2727 Main, Kansas City 64108, a graduate of National University, 1916; member Jackson County Medical Society; age 85; died Oct. 27, 1975.

Mary L. Schaef, M.D., 7450 Stanford, St. Louis 63130, a graduate of the University of Cincinnati, 1946; member St. Louis County Medical Societ age 59; died Oct. 31, 1975.

Bernard Friedman, M.D., 4511 Forest Par Blvd., St. Louis 63108, a graduate of the Universit of Wisconsin, 1934; member St. Louis Medica Society; age 66; died Nov. 5, 1975.

William L. Doane, M.D., 12820 Prospect Ave. Kansas City 64146, a graduate of the University o Kansas, 1952; member Jackson County Medica Society; age 52; died Nov. 9, 1975.

Jacob Stolar, M.D., 5 Big Bend Blvd., St. Louis 63105, a graduate of Washington University, 1928; member St. Louis Medical Society; age 74; died Nov. 10, 1975.

Joseph P. McEnery, M.D., 187 Concord Village Plaza, St. Louis 63128, a graduate of St. Louis University, 1967; member St. Louis Medical Society; age 34; died Nov. 13, 1975.

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RNING: Because of the potential hazard of nephrotoxicity and ototoxicity due to neomycin, care should be exercised when using this product in treating extensive burns, trophic ulceration and other extensive conditions where absorption of neomycin is possible. In burns where more than 20 percent of the body surface is affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended. **PRECAUTIONS**: As with other antibacterial preparations, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs. **ADVERSE REACTIONS:** Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section).

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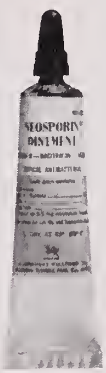

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Hypothyroid Cardiac	0.5-1.0 mg.	1.0 mg.	4.0 mg.	4.0 mg.

Choloxin®

(sodium dextrothyroxine)

Description

CHOLOXIN (sodium dextrothyroxine) is the sodium salt of the dextrorotatory isomer of thyroxine. It is chemically described as D-3,5,3′,5′-tetraiodothyronine sodium salt.

Actions

The predominant effect of CHOLOXIN (sodium dextrothyroxine) is the reduction of serum cholesterol levels in hyperlipidemic patients. Beta lipoprotein and triglyceride fractions may also be reduced from previously elevated levels.

Most of the available evidence indicates that CHOLOXIN stimulates the liver to increase catabolism and excretion of cholesterol and its degradation products via the biliary route into the feces. Cholesterol synthesis is not inhibited and abnormal metabolic end-products do not accumulate in the blood.

Indications

This is not an innocuous drug. Strict attention should be paid to the indications and contraindications.

CHOLOXIN (sodium dextrothyroxine) is an antilipidemic agent used as an adjunct to diet and other measures for the reduction of elevated serum cholesterol (low density lipoproteins) in euthyroid patients with no known evidence of organic heart disease.

The drug is also indicated in the treatment of hypothyroidism in patients with cardiac disease who cannot tolerate other types of thyroid medication.

Before prescribing, note the following: Results from a randomized clinical study have indicated a possible adverse effect when CHOLOXIN is administered to a patient receiving a digitalis preparation. There may be an additive effect. This additive effect may possibly stimulate the myocardium excessively in patients with significant myocardial impairment. CHOLOXIN dosage should not exceed 4 mg per day when the patient is receiving a digitalis preparation concomitantly. Careful monitoring of the total effect of both drugs is important.

It has not been established whether the drug-induced lowering of serum cholesterol or lipid levels has a detrimental, beneficial, or no effect on the morbidity or mortality due to atherosclerosis or coronary heart disease. Several years will be required before current investigations will yield an answer to this question.

Contraindications

The administration of CHOLOXIN (sodium dextrothyroxine) to euthyroid patients with one or more of the following conditions is contraindicated:

1. Known organic heart disease, including angina pectoris; history of myocardial infarction; cardiac arrhythmia or tachycardia, either active or in patients with demonstrated propensity for arrhythmias; rheumatic heart disease; history of congestive heart failure; and decompensated or borderline compensated cardiac status.
2. Hypertensive states (other than mild, labile systolic hypertension).
3. Advanced liver or kidney disease.
4. Pregnancy.
5. Nursing mothers.
6. History of iodism.

Warnings

CHOLOXIN (sodium dextrothyroxine) may potentiate the effects of anticoagulants on prothrombin time. Reductions of anticoagulant dosage by as much as 30% have been required in some patients. Consequently, the dosage of anticoagulants should be reduced by one-third upon initiation of CHOLOXIN therapy and the dosage subsequently readjusted on the basis of prothrombin time. The prothrombin time of patients receiving anticoagulant therapy concomitantly with CHOLOXIN therapy should be observed as frequently as necessary, but at least weekly, during the first few weeks of treatment.

In the surgical patient, it is wise to consider withdrawal of the drug two weeks prior to surgery if the use of anticoagulants during surgery is contemplated.

When CHOLOXIN is used as thyroid replacement therapy in hypothyroid patients with concomitant coronary artery disease (especially those with a history of angina pectoris or myocardial infarction) or other cardiac disease, treatment should be initiated with care. Special consideration of the dosage schedule of CHOLOXIN is required. This drug may increase the oxygen requirements of the myocardium, especially at high dosage levels. Treated subjects with coronary artery disease must be seen at frequent intervals. If aggravation of angina or increased myocardial ischemia, cardiac failure, or clinically significant arrhythmia develops during the treatment of hypothyroid patients, the dosage should be reduced or the drug discontinued.

Special consideration must be given to the dosage of other thyroid medications used concomitantly with CHOLOXIN. As with all thyroactive drugs, hypothyroid patients are more sensitive to a given dose of CHOLOXIN than euthyroid patients.

Epinephrine injection in patients with coronary artery disease may precipitate an episode of coronary insufficiency. This condition may be enhanced in patients receiving thyroid analogues. These phenomena should be kept in mind when catecholamine injections are required in sodium dextrothyroxine-treated patients with coronary artery disease.

Since the possibility of precipitating cardiac arrhythmias during surgery may be greater in patients treated with thyroid hormones, it may be wise to discontinue CHOLOXIN in euthyroid patients at least two weeks prior to an elective operation. During emergency surgery in euthyroid patients, and in surgery in hypothyroid patients in whom it may be advisable to withdraw therapy, the patients should be carefully observed.

There are reports that sodium dextrothyroxine in diabetic patients is capable of increasing blood sugar levels with a resultant increase in requirements of insulin or oral hypoglycemic agents. Special attention should be paid to parameters necessary for good control of the diabetic state in dextrothyroxine-treated subjects and to dosage requirements of insulin or other antidiabetic drugs. If sodium dextrothyroxine is later withdrawn from patients who had required an increase of insulin (or oral hypoglycemic agents) dosage during its administration, the dosage of antidiabetic drugs should be reduced and adjusted to maintain good control of the diabetic state.

When either or both impaired liver or kidney function are present, the advantages of CHOLOXIN therapy must be weighed against the possibility of deleterious results.

Usage in Women of Childbearing Age

Women of childbearing age with familial hypercholesterolemia or hyperlipemia should not be deprived of the use of this drug; it can be given to those patients exercising strict birth control procedures. Since pregnancy may occur despite the use of birth control procedures, administration of CHOLOXIN (sodium dextrothyroxine) to women of this age group should be undertaken only after weighing the possible risk to the fetus against the possible benefits to the mother. Teratogenic studies in two animal species have resulted in no abnormalities in the offspring.

Precautions

It is expected that patients on dextrothyroxine therapy will show greatly increased serum protein-bound-iodine levels. These increased serum PBI values are evidence of absorption and transport of the drug, and should NOT be interpreted as evidence of hypermetabolism; similarly, they may not be used for titrating the effective dose of CHOLOXIN (sodium dextrothyroxine). PBI values in the range of 10 to 25 mcg% in treated patients are common.

If signs or symptoms of iodism develop during CHOLOXIN therapy, the drug should be discontinued.

A few children with familial hypercholesterolemia have been treated with CHOLOXIN for periods of one year or longer with no adverse effects on growth. However, it is recommended that the drug be continued in patients in this age group only if a significant serum cholesterol-lowering effect is observed.

Adverse Reactions

The side effects attributed to dextrothyroxine therapy are, for the most part, due to increased metabolism, and may be minimized by following the recommended dosage schedule. Adverse effects are least commonly seen in euthyroid patients with no signs or symptoms of organic heart disease; the incidence of adverse effects is increased in hypothyroid patients, and is highest in those patients with organic heart disease superimposed on the hypothyroid state.

In the absence of known organic heart disease, some cardiac changes may be precipitated during sodium dextrothyroxine therapy. In addition to angina pectoris, arrhythmia consisting of extrasystoles, ectopic beats, or supraventricular tachycardia, ECG evidence of ischemic myocardial changes and increase in heart size have been observed. Myocardial infarctions, both fatal and non-fatal, have occurred, but these are not unexpected in untreated patients in the age groups studied. It is not known whether any of these infarcts were drug related.

Changes in clinical status that may be related to the metabolic action of the drug include the development of insomnia, nervousness, palpitations, tremors, loss of weight, lid lag, sweating, flushing, hyperthermia, hair loss, diuresis, and menstrual irregularities. Gastrointestinal complaints during therapy have included dyspepsia, nausea and vomiting, constipation, diarrhea, and decrease in appetite.

Other side effects reported to be associated with CHOLOXIN (sodium dextrothyroxine) therapy include the development of headache, changes in libido (increase or decrease), hoarseness, tinnitus, dizziness, peripheral edema, malaise, tiredness, visual disturbances, psychic changes, paresthesia, muscle pain, and various bizarre subjective complaints. Skin rashes, including a few which appeared to be due to iodism, and itching have been attributed to dextrothyroxine by some investigators. Gallstones have been discovered in occasional dextrothyroxine-treated patients and cholestatic jaundice has occurred in one patient, although its relationship to CHOLOXIN therapy was not established.

In several instances, the previously existing conditions of the patient appeared to continue or progress during the administration of CHOLOXIN; a worsening of peripheral vascular disease, sensorium, exophthalmos, and retinopathy have been reported.

CHOLOXIN potentiates the effects of anticoagulants, such as warfarin or Dicumarol, on prothrombin time, thus indicating a decrease in the dosage requirements of the anticoagulants. On the other hand, dosage requirements of antidiabetic drugs have been reported to be increased during dextrothyroxine therapy (see WARNINGS section).

Dosage and Administration

For **adult** euthyroid hypercholesterolemic patients, the recommended maintenance dose of CHOLOXIN (sodium dextrothyroxine) is 4 to 8 mg per day. The initial daily dose should be 1 to 2 mg to be increased in 1 to 2 mg increments at intervals of not less than one month to a maximum level of 4 to 8 mg daily, if that dosage level is indicated to effect the desired lowering of serum cholesterol.

When used as partial or complete substitution therapy for levothyroxine in hypothyroid patients with cardiac disease who cannot tolerate other types of thyroid medication, the initial daily dose should be 1 mg to be increased in 1 mg increments at intervals of not less than one month to a maximum level of 4 to 8 mg daily, preferably the lower dosage. The maximum in patients receiving digitalis therapy is 4 mg.

For **pediatric** hypercholesterolemic patients, the recommended maintenance dose of CHOLOXIN is approximately 0.1 mg per kilogram. The initial daily dosage should be approximately 0.05 mg per kilogram to be increased in up to 0.05 mg per kilogram increments at monthly intervals. The recommended maximal dose is 4 mg daily, if that dosage is indicated to effect the desired lowering of serum cholesterol.

If new signs or symptoms of cardiac disease develop during the treatment period, the drug should be withdrawn.

How Supplied

CHOLOXIN (sodium dextrothyroxine) is supplied in prescription packages of scored 1, 2, 4, and 6 mg tablets.

FLINT LABORATORIES
DIVISION OF TRAVENOL LABORATORIES INC
Deerfield, Illinois 60015

LEO H. POLLOCK, M.D.

Missouri Medicine in Review

FORTY YEARS AGO

A comprehensive resurvey of medical education as begun by the Council on Medical Education nd Hospitals in September, 1934. Realizing this eed, the Council solicited the cooperation of the ssociation of American Medical Colleges and the ederation of State Medical Boards of the United tates.

At the 1935 session, it was reported that 45 medi-al schools had been visited. At a meeting of the ouncil in Denver on September 15, certain sig-ificant weaknesses were revealed.

The Council took the following actions:

A. Resolved that in each medical school, the umber of students should not exceed the number hat can be adequately taught with the laboratory, ibrary and clinical facilities available and for hom a sufficiently large and competent teaching taff is provided.

B. Resolved, that after July 1, 1938, the Council n Medical Education and Hospitals will no longer ublish a list of approved two-year medical schools.

WENTY-FIVE YEARS AGO

Harold L. Gainey, M.D., Kansas City, was elect-d secretary-treasurer of the Central Association of bstetricians and Gynecologists at a meeting on eptember 21 in Milwaukee.

Charles A. Brasher, M.D., Mount Vernon, has een elected the Missouri Governor for the Ameri-an College of Chest Physicians for the years 1950 nd 1951.

Curtis H. Lehr, M.D., St. Louis, was elected egent of the American College of Hospital Ad-inistration at a meeting in Atlantic City on Sep-mper 19.

Otis E. James, Jr., M.D., Kansas City, addressed e staff of the Lexington Memorial Hospital on "The Treatment of Common Fractures" on September 5.

Horace Wendell Soper, M.D., St. Louis, served as president of the National Gastroenterological Association at a meeting held in New York on October 9-11.

Evarts A. Graham, M.D., St. Louis was elected to the board of regents of the American College of Surgeons at a meeting on October 26. Cyrus E. Burford, M.D. and J. Albert Key, M.D. of St. Louis were elected to the board of governors for three-year terms.

James R. McVay, M.D., Kansas City, was re-elected chairman of the Council on Medical Services of the American Medical Association at a meeting in Chicago on September 14-15.

TEN YEARS AGO

Dr. William H. Danforth, St. Louis, has been elected president of the Washington University School of Medicine and Affiliated Hospitals Board for a term of three years. He succeeds Dr. Carl V. Moore, who served as the first president of the Board. Dr. Moore asked to be relieved of his administrative office to devote full time to his position as professor and head of the Department of Medicine. Dr. Danforth recently was appointed Washington University's Vice-Chancellor for Medical Affairs.

The new Social Security "Medicare" law probably will be reconsidered by Congress in about five years, according to Rep. Thomas B. Curtis (R-Mo.). The congressman made the prediction while addressing the annual meeting of the Jackson County Medical Society in Kansas City. About 200 physician-members attended the meeting. Dr. Harry Statland, President of the JCMS, presided over the brief business meeting in which Society members approved a continuation of their present dues schedule.

Neurosurgeons and many other physicians are acquainted with the name of Dr. Walter E. Dandy, and his monumental contributions to neurosurgery. Walter Dandy's early life in Sedalia is less well known, but it clearly showed his superiority and forecast his future greatness.

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Before prescribing, please consult complete product information, a summary of which follows:

Indications: Relief of anxiety and tension occurring alone or accompanying various disease states.
Contraindications: Patients with known hypersensitivity to the drug.
Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.
Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.
Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.
Usual Daily Dosage: Individualize for maximum beneficial effects. *Oral—Adults:* Mild and moderate anxiety and tension, 5 to 10 mg *t.i.d.* or *q.i.d.*; severe states, 20 or 25 mg *t.i.d.* or *q.i.d. Geriatric patients:* 5 mg *b.i.d.* to *q.i.d.* (See Precautions.)
Supplied: Librium® (chlordiazepoxide HCl) *Capsules*, 5 mg, 10 mg and 25 mg—bottles of 100 and 500; Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10; Prescription Paks of 50, available singly and in trays of 10. Libritabs® (chlordiazepoxide) *Tablets*, 5 mg, 10 mg and 25 mg—bottles of 100 and 500. With respect to clinical activity, capsules and tablets are indistinguishable.

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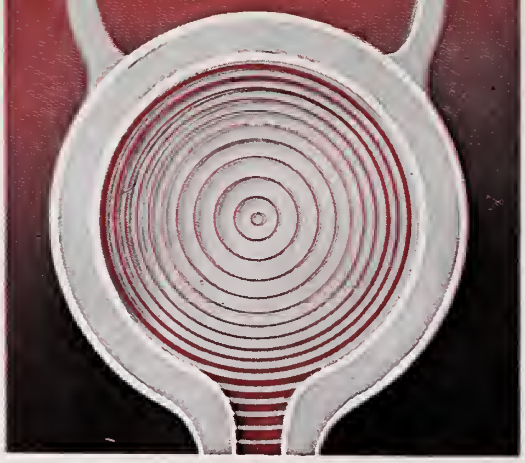

IN PAINFUL ACUTE CYSTITIS*

*nonobstructed; due to susceptible organisms

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WHILE YOU ELIMINATE THE PATHOGENS.

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☐ **Early relief of painful symptoms** such as burning and pain associated with urgency and frequency.

FOR THE PATHOGENS

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Appropriate antibacterial therapy: Up to 3 days therapy with Azo Gantrisin 4 to 6 tablets *Stat.*, then 2 tablets *q.i.d.*; then 11 days with Gantrisin (sulfisoxazole) may be considered.

AZO GANTRISIN®

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Before prescribing, please consult complete product information, a summary of which follows.

Indications: In adults, urinary tract infections complicated by pain (primarily cystitis, pyelitis and pyelonephritis) due to susceptible organisms (usually *E. coli, Klebsiella-Aerobacter, Staphylococcus aureus, Proteus mirabilis,* and, less frequently, *Proteus vulgaris*) in the absence of obstructive uropathy or foreign bodies.

Important Note: Carefully coordinate *in vitro* sulfonamide sensitivity tests with bacteriologic and clinical response. Add aminobenzoic acid to culture media for patients already taking sulfonamides. Increasing frequency of resistant organisms currently is a limitation of the usefulness of antibacterial agents including the sulfonamides. Blood levels should be measured in patients receiving sulfonamides for serious infections, since there may be wide variations with identical doses; 12 to 15 mg/100 ml is considered optimal for serious infections; 20 mg/100 ml should be the maximum total sulfonamide level, as adverse reactions occur more frequently above this level.

Contraindications: Children below age 12; sulfonamide hypersensitivity; pregnancy at term and during nursing period. Contraindicated in glomerulonephritis, severe hepatitis, uremia, and pyelonephritis of pregnancy with gastrointestinal disturbances, because of phenazopyridine HCl component.

Warnings: Safe use in pregnancy has not been established. Teratogenicity potential has not been thoroughly investigated. Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been reported; clinical signs such as sore throat, fever, pallor, purpura or jaundice may be early indications of serious blood disorders. Complete blood counts and urinalysis with careful microscopic examination should be performed frequently during sulfonamide therapy.

Precautions: Use with caution in patients with impaired renal or hepatic function, severe allergy, bronchial asthma and in glucose-6-phosphate dehydrogenase-deficient individuals. In the latter, hemolysis may occur. Maintain adequate fluid intake to prevent crystalluria and stone formation.

Adverse Reactions: *Blood dyscrasias:* Agranulocytosis, aplastic anemia, thrombocytopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. *Allergic reactions:* Erythema multiforme (Stevens-Johnson syndrome), skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. *Gastrointestinal reactions:* Nausea, emesis, abdominal pains, hepatitis, diarrhea, anorexia, pancreatitis and stomatitis. *C.N.S. reactions:* Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo and insomnia. *Miscellaneous reactions:* Drug fever, chills, toxic nephrosis with oliguria and anuria, polyarteritis nodosa and L.E. phenomenon. Due to certain chemical similarities with some goitrogens, diuretics (acetazolamide and thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia. Cross-sensitivity with these agents may exist.

Dosage: Usual adult dosage for acute, painful phase of urinary tract infections is 4 to 6 tablets initially, then 2 tablets four times daily for up to 3 days. If pain persists, causes other than infection should be sought. After relief of pain has been obtained, continued treatment of the infection with Gantrisin (sulfisoxazole) may be considered.

Note: Patients should be told that the orange-red dye (phenazopyridine HCl) will color the urine soon after ingestion.

How Supplied: Tablets, each containing 0.5 Gm sulfisoxazole and 50 mg phenazopyridine HCl —bottles of 100 and 500.

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